

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13267 CERTIFICATE OF DEATH

14351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>2 mo. 4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P. O. Box 75, Church Creek</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>09X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie Akon</u> Middle _____ Last _____				4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (In years lost birthday) <u>58?</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Riney Brannoch</u>				14. MOTHER'S MAIDEN NAME <u>Mary R. Brannoch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia and Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiovascular accident</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain syndrome associated with generalized arterio</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 10, 19 59</u> to <u>Dec. 31, 19 59</u> that I last saw the deceased alive on <u>Dec. 31, 19 59</u> and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ludwig Benedict</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Field</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Steward</u>				24a. RECEIVED BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935

1935

1935

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND Items 12.23 FilmG254 1-20-60 et 13268 CERTIFICATE OF DEATH

13221

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> <u>Jessups</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> <u>Jessups</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>				c. LENGTH OF STAY IN 1b <u>47 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jessups</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>VAITEKUS</u> Middle <u>BARONAS</u> Last <u>DEC</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1867</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>??</u>				13. FATHER'S NAME <u>Heckman</u>			
14. MOTHER'S MAIDEN NAME <u>Heckman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>480x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Influenza</u> DUE TO (c) <u>Gen'l Arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk</u> <u>15 yrs</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TOTAL SENILE DEMENTIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/20/59</u> to <u>12/1/59</u> , that I last saw the deceased alive on <u>11/27/59</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> P. M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>M Warren</u>				DATE SIGNED <u>Laurel M 12/1/59</u>			
ACTUAL SIGNATURE <u>M Warren</u>				M.D. <u>Laurel M 12/1/59</u>			
PHYSICIAN'S NAME (Type) <u>M Warren</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heads of the Cemetery, Dorsey</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Wachsman</u>				ADDRESS <u>637 Wash Blvd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>							

CERTIFICATE OF DEATH

1922

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.



Vertical text on the right margin, likely a filing or archival note.

13269

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Hgts.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Hgts.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>551 Shipley Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>John H. Berry</b>				4. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 16, 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafarer (ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Thomas Berry</b>				14. MOTHER'S MAIDEN NAME <b>Mary Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-16-7413</b>		INFORMANT Address <b>Mary L. Smith 551 Shipley Rd. Linth. Hgts</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio vascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 28, 1957</b> to <b>Dec. 27, 1959</b> , that I last saw the deceased alive on <b>Dec. 26, 1959</b> , and that death occurred at <b>4:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George A. Knipp</b>				ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b> DATE SIGNED <b>12/28/59</b>			
PHYSICIAN'S NAME (Type) <b>George Knipp, M.D.</b>				ADDRESS <b>4116 Edmondson Avenue</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12'30'59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>George S. Knipp</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John F. Kennedy  
201 Madison Ave.  
New York 17, N.Y.  
April 16, 1955  
Dear Mr. Kennedy:  
I am writing to you in response to your letter of April 14, 1955, regarding the matter of the proposed amendment to the Federal Reserve Act. I am very interested in the subject and am sure that your views will be of great value to the Commission.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13236

## CERTIFICATE OF DEATH

15223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>1 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROY EUGENE BEST</b>				4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 June 1890</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meter Reader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>HENRY BEST</b>				14. MOTHER'S MAIDEN NAME <b>MARY SUDDATH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577 05 0562</b>		17. INFORMANT <b>Mrs. Dorthoy May Epstein (Daughter) 119 Alameda Parkway, Arnold, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> <b>HEPATIC COMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Melastatic Carcinoma Prostate</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>10 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-4-59</b> , 19 <b>59</b> , to <b>12-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1045</b> , 19 <b>59</b> , and that death occurred at <b>1105A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. 12-9-59</b>							
ACTUAL SIGNATURE <b>Sylvan Busch</b>		M.D. <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>					
PHYSICIAN'S NAME (Type) <b>SYLVAN BUSCH LT MC USN</b>		<b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-12-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





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FOR STATE  
HEALTH DEPT.  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13224

1. PLACE OF DEATH a. COUNTY <b>13270</b> <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ft. Smallwood Rd., Box 301</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Ft. Smallwood Rd., Box 301</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>A.</b> Last <b>BLUHM</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1885</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baking</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Adolph Bluhm</b>			
14. MOTHER'S MAIDEN NAME <b>Louisa</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ruth Bluhm Box 301 Rt. 8, Pasadena, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/7/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Dec. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>	
22d. LOCATION (City, town, or country) (State) <b>Frederick Rd. Balto., Md.</b>		23. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hwy. (25)</b>			
24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

2

1455

13870

11

1

*Respectfully,  
J. M. [Signature]*

13237

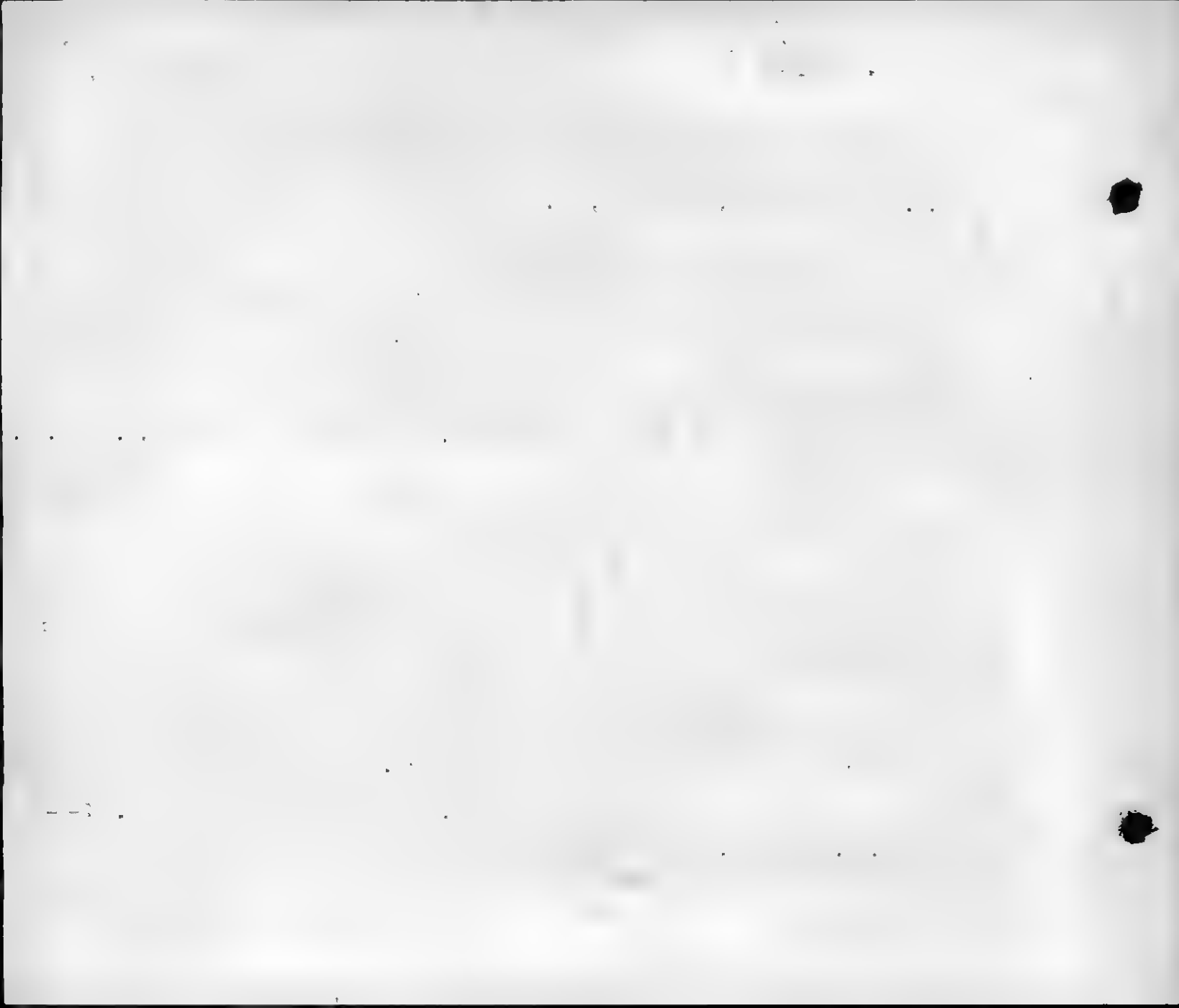
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Annapolis, Md.</b>				d. STREET ADDRESS <b>124 Charles Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eveline Green BOWERS</b>				4. DATE OF DEATH Month Day Year <b>12 5 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 January 1878</b>		9. AGE (in years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Richard Green</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Kent</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Richard H. BOWERS 6128 32nd Place N.W. Wash. D.C.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>400.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 Dec</b> , 19 <b>59</b> , to <b>5 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5 Dec</b> , 19 <b>59</b> , and that death occurred at <b>10: P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Annapolis, Md. 12-6-59</b>							
ACTUAL SIGNATURE <b>W. F. KRONE JR. LT MC USNR</b>				M.D. <b>U.S. Naval Hospital, Annapolis, Md. 12-6-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>BURIAL</b>		<b>Dec. 10-59</b>		<b>Naval Academy</b>		<b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Taylor Sons</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

13226

Reg. Dist. No.

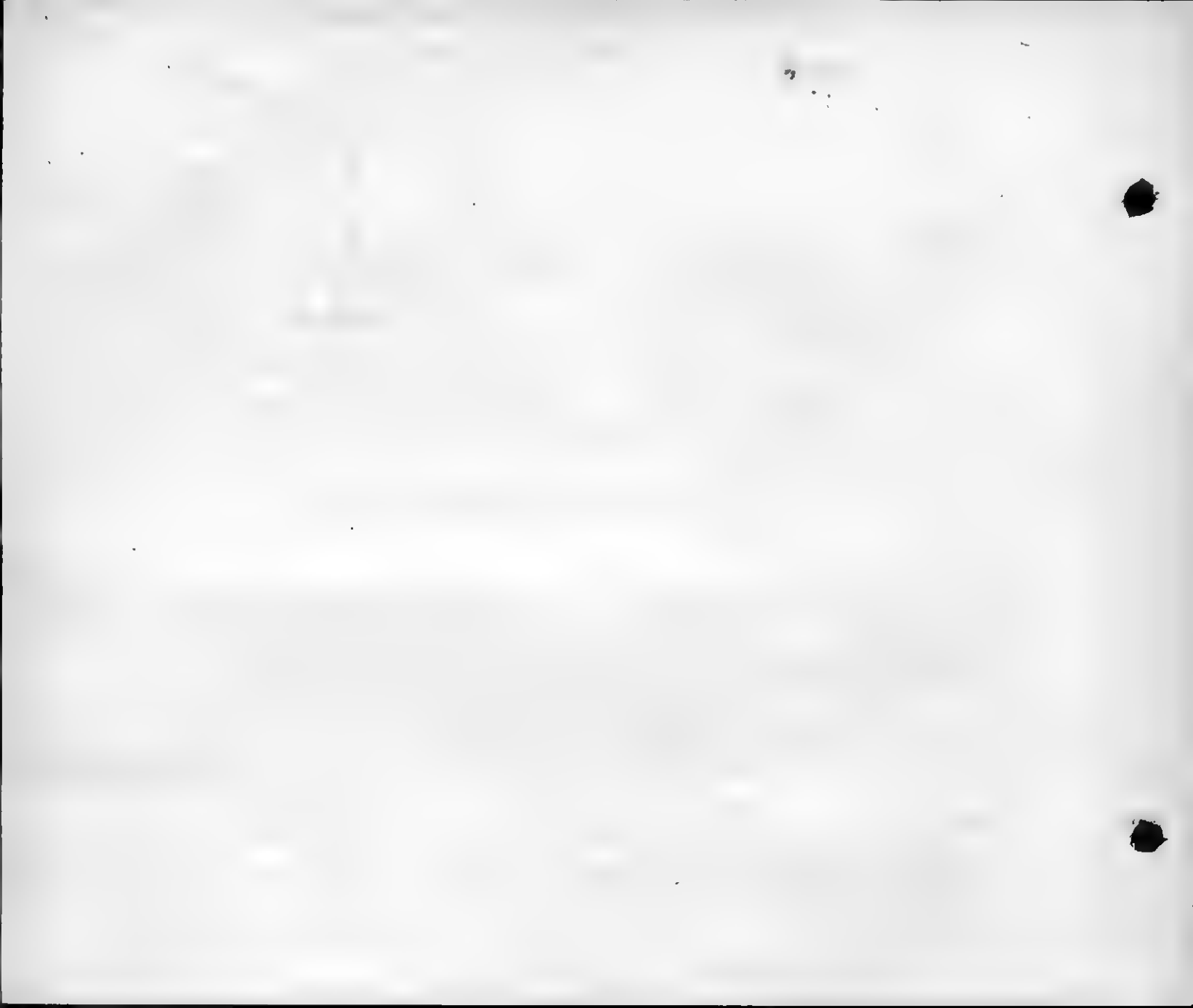
13238

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annie Arundel Gen Hosp</u>				d. STREET ADDRESS <u>Arundel Beach Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Garnett Lyle</u> First <u>Bowie</u> Middle Last				4. DATE OF DEATH <u>Dec 1</u> 19 <u>59</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 11-1907</u>	
9. AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NSA</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Wm. Frank</u>				14. MOTHER'S MAIDEN NAME <u>Beckley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>577-10-6925</u>		17. INFORMANT <u>Son: Homer Bowie</u> Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Deterioration</u> 1021 DUE TO <u>Generalized Carcinomatosis</u> (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>Stomach</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1956</u> 19 <u>56</u> to <u>1959</u> 19 <u>59</u> that I last saw the deceased alive on <u>11-30-59</u> 19 <u>59</u> and that death occurred at <u>11 A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE: <u>Robert R. Hoban</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>12-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hoban</u>				<u>Severna Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Isaacs, Mgr.</u>				ADDRESS <u>ARLINGTON, VA.</u>		24a. REC'D BY REGISTRAR DATE DEC 4 '59	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

13239

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>GARFIELD</u> Last <u>BRICE</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 18, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Com-Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George H. Brice</u>		14. MOTHER'S MAIDEN NAME <u>Ida Stinchcomb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Central vascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch. Congestive failure + u. R. 10-2 per</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-25-59</u> , to <u>12-26-59</u> , that I last saw the deceased alive on <u>12-25-59</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u> DATE SIGNED <u>12-26-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Margaret's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>St. Margaret's P.O. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1959</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13228

13271

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>1mo. 5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>209 W. Bethel Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Burnett</u> Last <u>Burnett</u>				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Syphilitic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>59</u> , to <u>12/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>59</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Crownsville State Hospital, Md.</u> <u>12/21/59</u>					
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D.</u>		<u>Crownsville State Hospital, Md.</u> <u>12/21/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 24 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John K Watson of Hagerstown</u>				ADDRESS <u>917</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13229

Reg. Dist. No.

13272

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bacontown</u>				d. STREET ADDRESS <u>same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wally</u> Middle <u>Bussell</u> Last <u>Edel</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1900</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Kent - Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD Tyler</u>				14. MOTHER'S MAIDEN NAME <u>LORETTA BANKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-32-7357</u>		17. INFORMANT <u>Rogers Bussell (husband)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260X</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Life</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Hustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>HUSTAVIE H. FAUBERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beacon Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, A A Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby, 1200 Snowden Place, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





13273

## CERTIFICATE OF DEATH

13230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10/30/59</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSTOWN STATE HOSPITAL</u>				e. STREET ADDRESS <u>55 N. BETHEL ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRIET</u> Middle <u>ELLEN</u> Last <u>BUTLER</u>				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/86</u>	
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months _____ Days _____ Hours _____		IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>HARRISBURG PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NE</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA C.V.A.</u>							<u>Few days</u>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>GENERALIZED ARTERIO SCLEROSIS</u>							<u>MANY YEARS</u>
DUE TO							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>CHRONIC BRAIN SYNDROME ASS. WITH SENILITY</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10/30</u> , 19 <u>59</u> , to <u>12/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>59</u> , and that death occurred at <u>7:20</u> A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>				M.D. <u>CROWNSTOWN STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				<u>CROWNSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Watson</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, whose name should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13274

Items 13, 17 - 11, 12, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

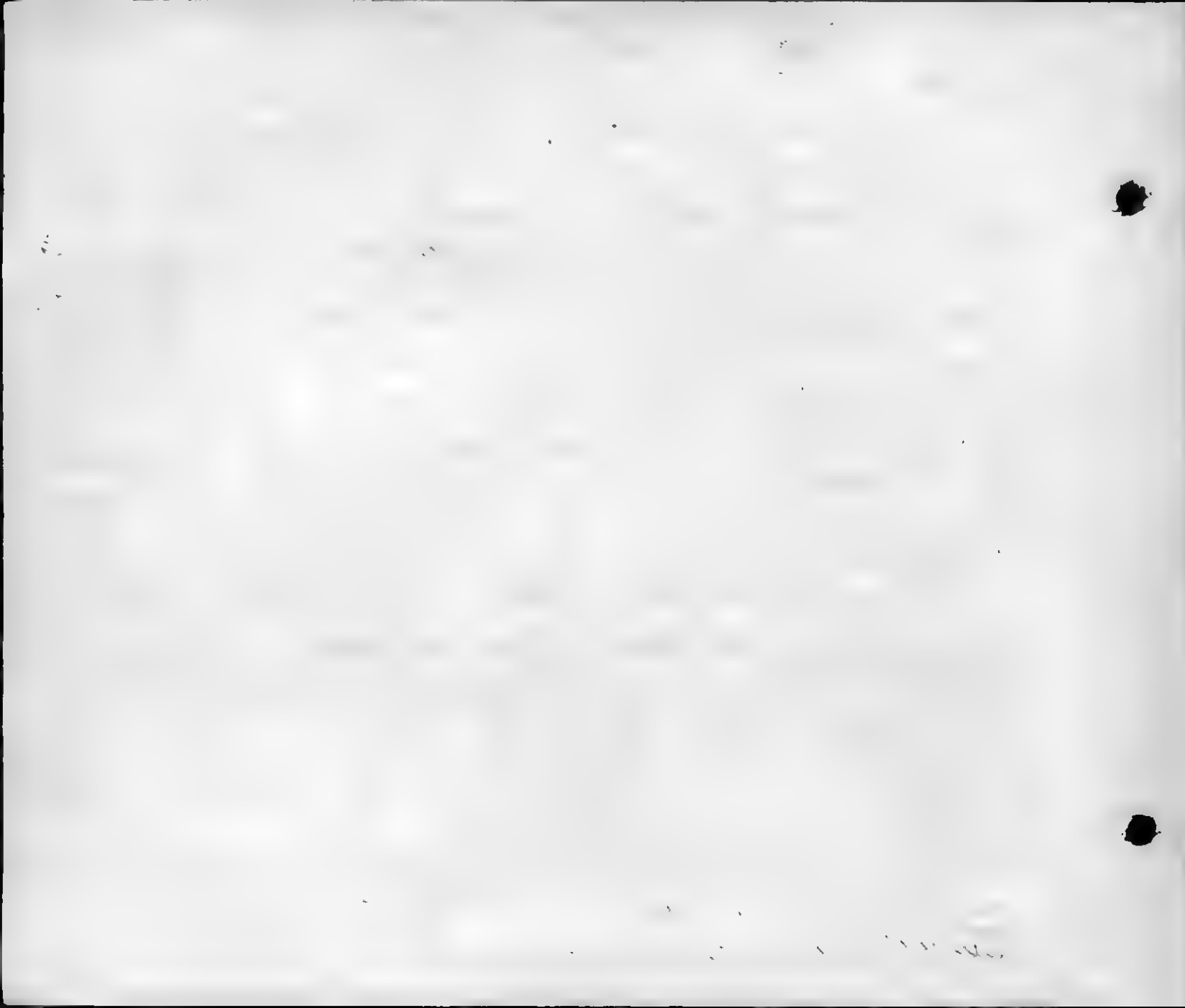
## CERTIFICATE OF DEATH

13231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A. ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same as 1B.</b>			
c. LENGTH OF STAY IN It <b>1 yr.</b>				d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>SCOTT AVE &amp; COOPER RD.</b>			
d. NAME OF DECEASED (Type or print) <b>WILLIAM ALEXANDER CARROLL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ALEXANDER CARROLL</b>				4. DATE OF DEATH <b>DEC - 3 1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 DEC 1958</b>	
9. AGE (In years last birthday) <b>11</b>		10. IF UNDER 1 YEAR <b>11</b> Months <b>16</b> Days		11. IF UNDER 24 HRS <b>11</b> Hours <b>16</b> Min		12. CITIZEN OF WHAT COUNTRY? <b>child</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>child</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland - John Hopkins Univ child</b>				12. CITIZEN OF WHAT COUNTRY? <b>child</b>			
13. FATHER'S NAME <b>William Alexander Carroll</b>				14. MOTHER'S MAIDEN NAME <b>Audrey Generette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>none</b>				16. SOCIAL SECURITY NO. <b>Carroll</b>			
17. INFORMANT <b>Father - Wm. Alexander Carroll</b>				Address <b>Carroll</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>upper respiratory infection</b> DUE TO (c) <b>14 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>901 EDGERLY RD.</b>				20f. (City or town) <b>GLEN BURNIE, MD.</b> (County) <b>A. ARUNDEL</b> (State) <b>MD.</b>			
21. I certify that I attended the deceased from <b>6-5</b> , 19 <b>59</b> , to <b>12-3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-3</b> , 19 <b>59</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>901 EDGERLY RD. GLEN BURNIE, MD.</b>				DATE SIGNED <b>3 Dec 59</b>			
ACTUAL SIGNATURE <b>H-F Manuzak</b>				M.D. <b>901 EDGERLY RD.</b>			
PHYSICIAN'S NAME (Type) <b>H-F. MANUZAK</b>				GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Marky Neck Cem.</b>		22d. LOCATION (City, town, or county) <b>A.A.C. Md.</b> (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. O. Wilson</b>				ADDRESS <b>108 Broadway Ave</b>			
24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>			

205-1-1X



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13232

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Anne Arundel</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RT-1 - Brownlow</i>				e. STREET ADDRESS <i>14 ME.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>Larry Lee Carter</i>				<b>4. DATE OF DEATH</b> Month Day Year <i>Dec. 27 1959</i>			
<b>5. SEX</b> <i>M</i>		<b>6. COLOR OR RACE</b> <i>C</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>8/24/59</i>	
<b>9. AGE</b> (In years last birthday) yrs. <i>24</i>		<b>10. IF UNDER 1 YEAR</b> Months <i>4</i> Days <i>2</i>		<b>11. IF UNDER 24 HRS</b> Hours <i>2</i> Min <i>5</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>None</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>None</i>			
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Princeton Hospital, Maryland</i>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>			
<b>13. FATHER'S NAME</b> <i>Lester Warren Carter</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Dolores Day</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>				<b>16. SOCIAL SECURITY NO.</b> <i>None</i>		<b>17. INFORMANT</b> <i>Master</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Malnutrition</i> (b) <i>172.5</i> (c) <i>Asphyxiation due to ligature</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Heart</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Wgt. at b. 2'6"</i> (b) _____ (c) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Eustace H. Faubert</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <i>EUSTACE H. FAUBERT</i>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <i>12/27/59</i>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>12-30-59</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Beacon Chapel</i>		<b>22d. LOCATION (City, town, or county) (State)</b> <i>Laurel, Md</i>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>R. Selby</i>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <i>DEC 31 '59</i>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>				<b>24c. REGISTRAR'S SIGNATURE</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



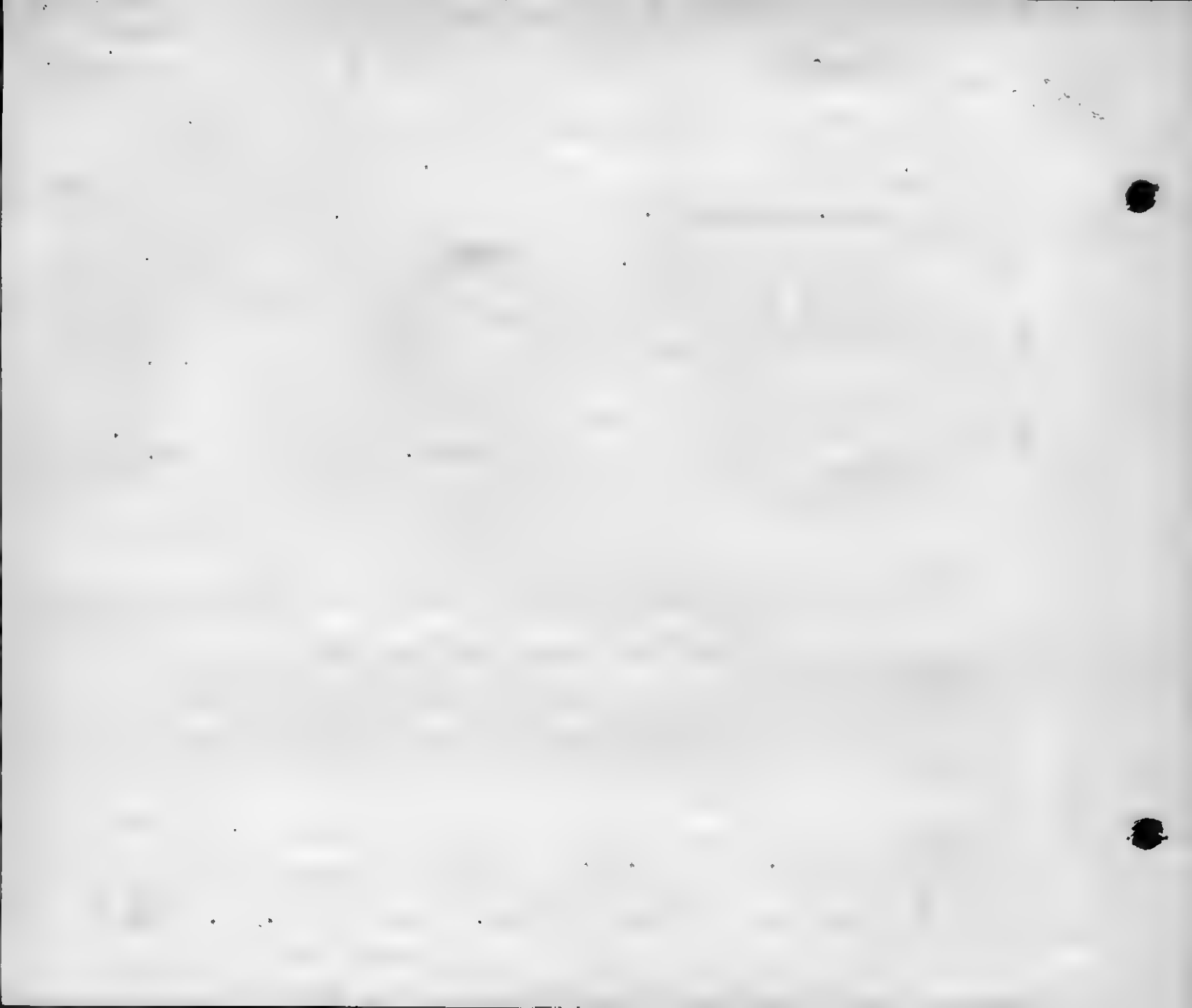


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A111ME  
SM 7/59

<div> <div>10&amp;21-File-3ms</div> <div>13276</div> <div>13233</div> </div> <div> <div>10&amp;21-File-3ms</div> <div>13276</div> <div>13233</div> </div>																					
<div> <div>10&amp;21-File-3ms</div> <div>13276</div> <div>13233</div> </div> <div> <div>10&amp;21-File-3ms</div> <div>13276</div> <div>13233</div> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home - St. Margarets, Md.</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> d. STREET ADDRESS <u>Route No. 4</u>																
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LEON</u> Middle <u>V.</u> Last <u>CATTAN</u>					<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>2</u> Year <u>1959</u>																
<b>5. SEX</b> <u>Male</u>					<b>6. COLOR OR RACE</b> <u>White</u>																
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>					<b>8. DATE OF BIRTH</b> <u>June 25, 1902</u>																
<b>9. AGE</b> (In years last birthday) <u>57</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Mins.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>					IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Mins.									
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Mins.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>electronics</u>																
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Switzerland</u>					<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>																
<b>13. FATHER'S NAME</b> <u>Leon Cattan</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Schultz</u>																
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>					<b>16. SOCIAL SECURITY NO.</b>																
<b>17. INFORMANT</b> <u>Mrs. Bertha M. Cattan - Route 4, St. Margarets</u>					<b>Address</b> <u>Md.</u>																
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Methyl alcohol poisoning</u> DUE TO (b) <u>XX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)																
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.					<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					<b>20f. (City or town)</b> (County) (State)																
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>William W. Lovitt, Jr.</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>																
<b>EXAMINER'S NAME (Type)</b> <u>William W. Lovitt, Jr., M.D.</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>					<b>DATE SIGNED</b> <u>12/3/59</u>																
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>					<b>22b. DATE THEREOF</b> <u>12/4/59</u>																
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Mount Crem.</u>					<b>22d. LOCATION (City, town, or country)</b> <u>Balto., Md.</u>																
<b>23. FUNERAL DIRECTOR</b> <u>St. Mary's The Roman Catholic Church - Balto.</u>					<b>24a. REC'D BY REGISTRAR</b> <u>DEC 8 '59</u>																
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur P. Hume</u>																					



## CERTIFICATE OF DEATH

Reg. Dist. No.

13277

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>	
c. LENGTH OF STAY IN 1b <u>13 yrs.</u>		d. STREET ADDRESS <u>238 Hammonds Ferry Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>238 Hammonds Ferry Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>T.</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Feb. 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.C. Road Com.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.C. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Sarah M. Chaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Mrs. Myrtle W. Chaney</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO <u>Asthma - Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u> <u>20-25 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1936</u> to <u>12/19/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/19/59</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball</u>		ADDRESS (Street, city or town, state) <u>Linthicum Md.</u> DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>203 W. Maple Rd.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>21 Dec 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur G. Winterton</u> ADDRESS <u>6100 Buxton Rd.</u>		24a. REC'D BY REGISTRAR <u>Arthur G. Winterton</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur G. Winterton</u>	
DATE <u>DEC 23 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician be executed within 24 hours after death. The law requires that the attending physician be executed within 24 hours after death.

VS A15 (4)  
1SM 10/57



13278

## CERTIFICATE OF DEATH

Reg. Dist. No.

13235

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fort Belvoir</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Regimental Hospital</i>		d. STREET ADDRESS <i>925 S. Sharpe Street</i>	
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Clark</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>December</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 16, 1873</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>12</i> Hours <i>15</i> Min.	IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Plaza Manor Hospital Records, Glen Burnie, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) <i>Hypertensive cerebral vascular disease</i> DUE TO (c) <i>Chronic atherosclerosis - Sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic atherosclerosis - Sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>12</i> Day <i>23</i> Year <i>1959</i> Hour <i>11</i> a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/17/59</i> to <i>12/23/59</i> , that I last saw the deceased alive on <i>12/17/59</i> , and that death occurred at <i>11:15</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William A. Jackson</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 37, Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>John S. Gaudin</i>		DATE SIGNED <i>12/23/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-24-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William A. Jackson</i>		ADDRESS <i>Funeral Home Inc. 916 Penna. Ave.</i>	
24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

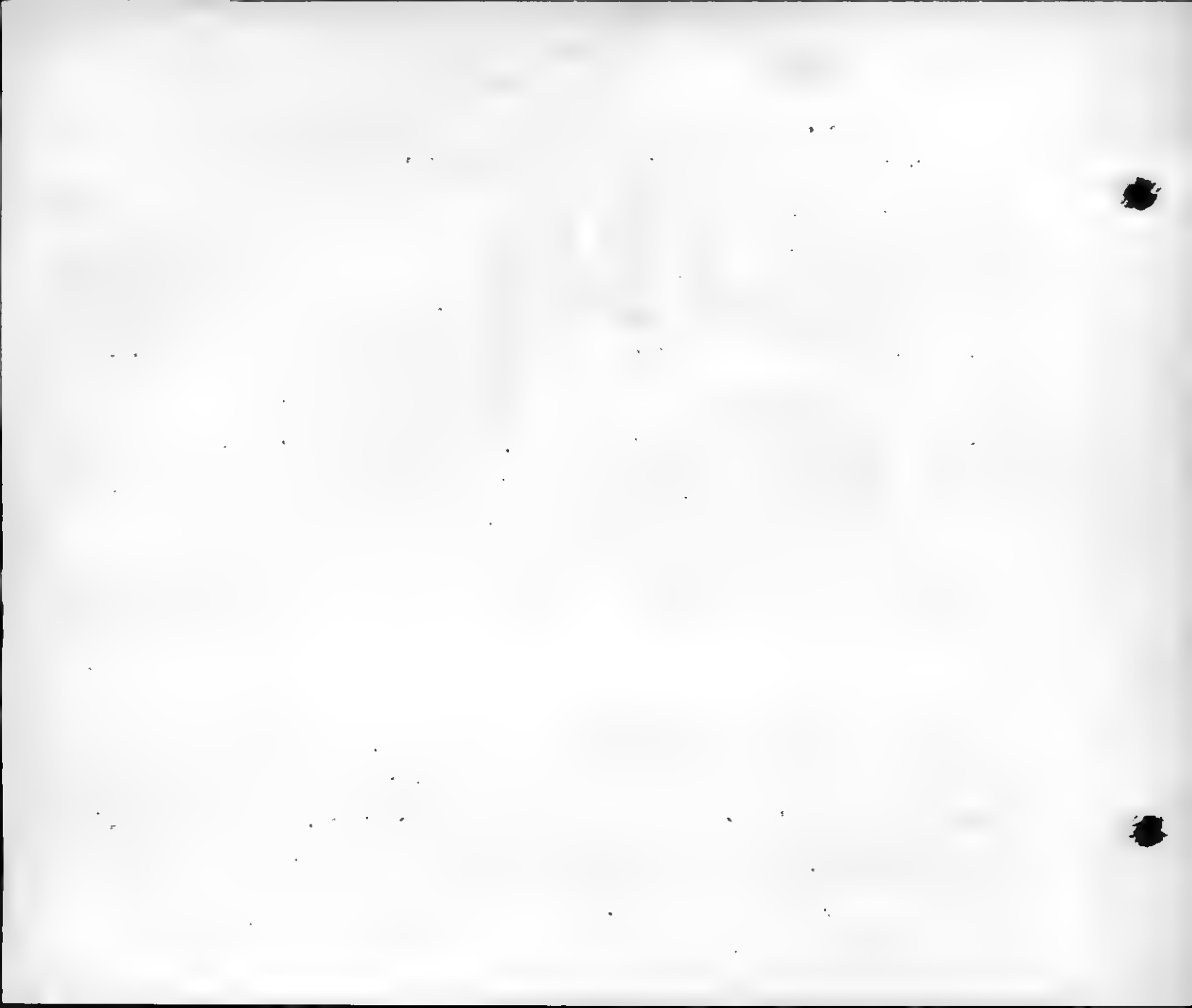
Reg. Dist. No.

13240

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>5 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harrison</b> Last <b>CRANDELL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1893</b>	
9. AGE (In years lost birthday) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		11. IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland, Shadyside</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John A. CRANDALL</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Evans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO <b>212-18-4249</b>			
17. INFORMANT <b>Ruby Eugenia CRANDALL</b>				Address <b>Shadyside Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aortic stenosis</b> <b>416x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Rheumatic heart disease</b> DUE TO (c) <b>54 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>Dec.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 3</b> , 19 <b>59</b> , and that death occurred at <b>3:25 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John L. Hedeman</b>				ADDRESS (Street, city or town, state) <b>121 Cathedral St.,</b> DATE SIGNED <b>12/4/59</b>			
PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/7/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>				22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Nardocety</b> ADDRESS <b>Salisbury</b>				24a. REC'D BY REGISTRAR <b>DEC 9 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





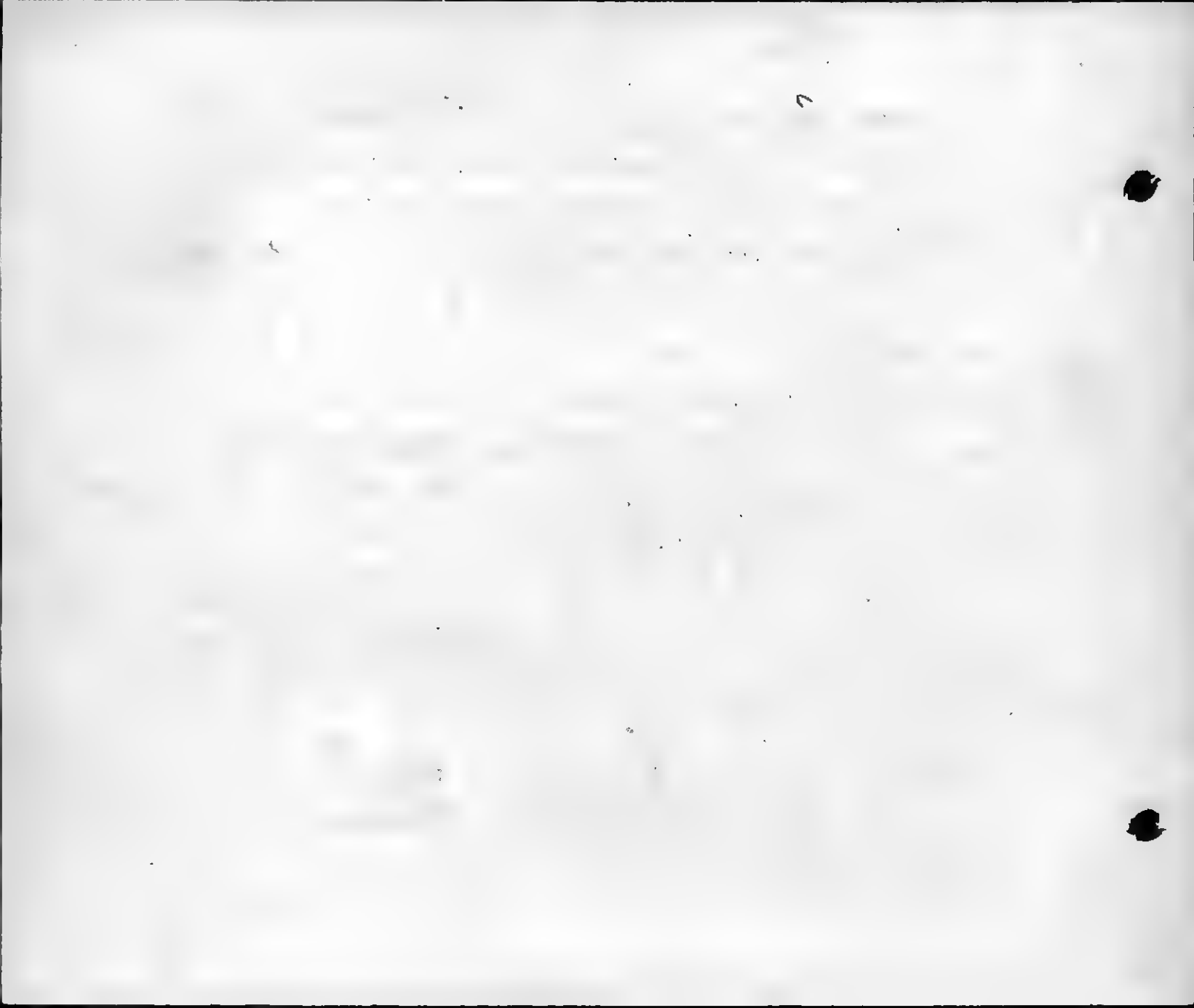


13279. Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 3 File G-54 12-31-59 et  
**CERTIFICATE OF DEATH**

13238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>A.A.Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLEKSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SARIN'S NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernard Donaldson</b> First Middle (Donaldson)		4. DATE OF DEATH <b>12/29/59</b> 19 <b>59</b> Month Day Year	
5. SEX <b>MC</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 20, 1886</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOFFERS</b>	
11. BIRTHPLACE (State or foreign country) <b>SEVERN, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>DAVID F. DONALDSON</b>		14. MOTHER'S MAIDEN NAME <b>STEEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-8562</b>	
INFORMANT <b>MARY NEWBERGER</b> Address <b>MILLERSVILLE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Citic Company Throat</b> DUE TO (b) <b>Pulmonary Edema</b> DUE TO (c) <b>Cardio Vasc. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis Spine</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>Dec 24/59</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 24/59</b> to <b>Dec 29/59</b> , that I last saw the deceased alive on <b>Dec 24/59</b> and that death occurred at <b>Dec 29/59</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>12/30/59</b> DATE SIGNED	
ACTUAL SIGNATURE <b>R. JOSEPH LIPSKEY</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOSEPH LIPSKEY</b> MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>7/2/59</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kline</b> ADDRESS <b>130 E Fort Ave</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13239

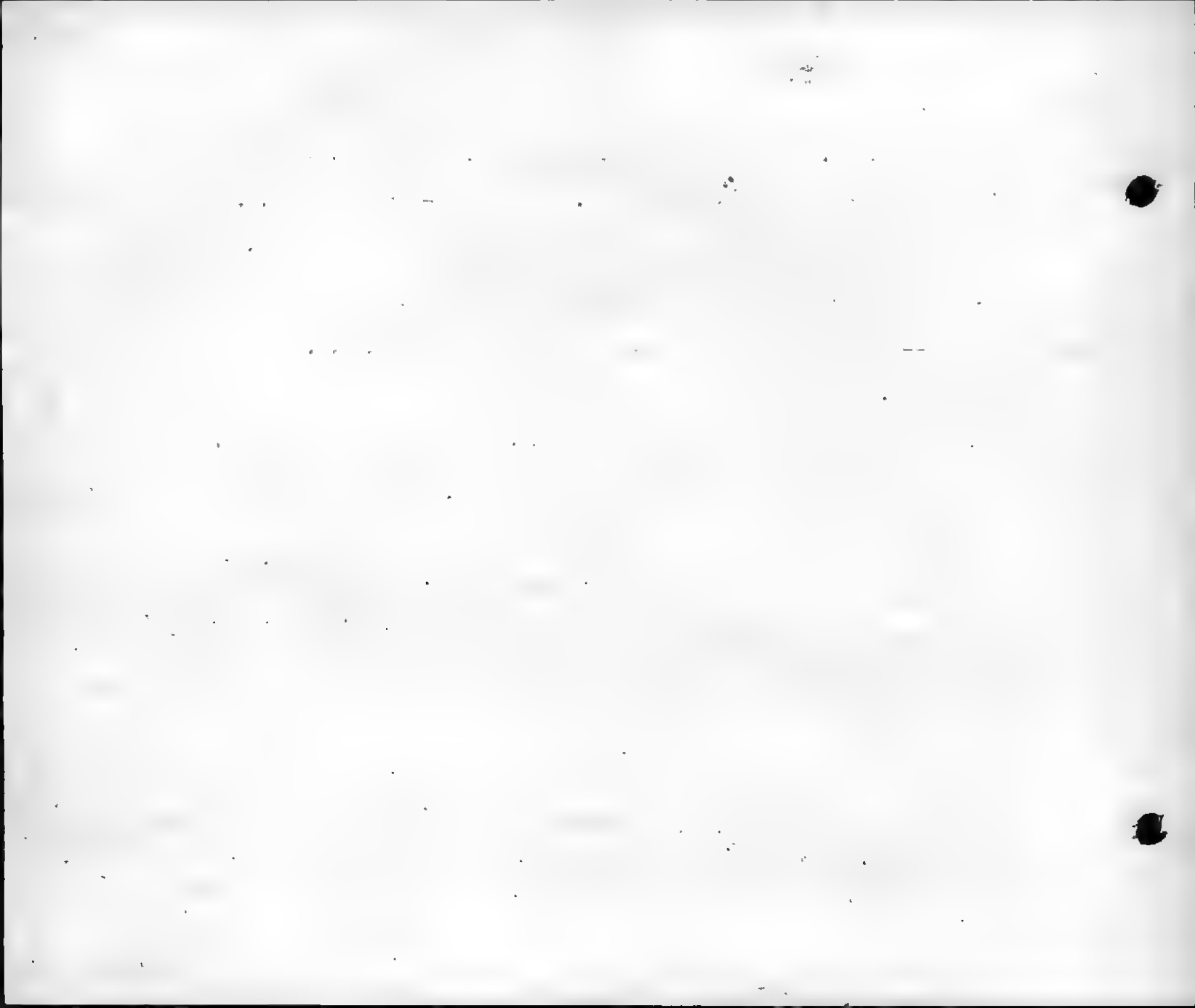
13280

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md.</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) <b>Children's Center District Training School, Laurel, Md.</b>		e. STREET ADDRESS <b>4625 - 8th Street N.W.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Field</b> Last <b>Field</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 14, 1920</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James E. Field</b>		14. MOTHER'S MAIDEN NAME <b>Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>Children's Center, Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>(Sensitized)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Chronic upper respiratory disease</b> (b) <b>mental deficiency, idiocy, frontal lobe atrophy</b> (c) <b>---</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>56</b> , to <b>Dec. 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 15</b> , 19 <b>59</b> , and that death occurred at <b>11:45</b> AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantraut</b>		ADDRESS (Street, city or town, state) <b>Children's Center</b>		DATE SIGNED <b>12/16/59</b>	
PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut</b>		<b>Laurel, Md.</b>			
22a. (URIA) CREMATION, 22b. DATE THEREOF <b>12-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Deal</b>		ADDRESS <b>4812 Geo. ave.</b>		24a. REC'D BY REGISTRAR <b>---</b>	
				24b. REGISTRAR'S SIGNATURE <b>---</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 21 '59





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13240

13281

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Elvaton -</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNIE ARUNDEL GENERAL</u>				e. STREET ADDRESS <u>Ridge - Road.</u>			
3. NAME OF DECEASED (Type or print) <u>Edgar R Ford</u>				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892 Apr 26</u>		9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor finisher (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ford</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Jeffery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-22-5880</u>		17. INFORMANT <u>Mrs. Alice Klein</u> Address <u>Same as dec</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cancer</u> DUE TO (c) <u>  </u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>  </u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 Dec 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>AA Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE DEC 10 '59	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13242

## CERTIFICATE OF DEATH

Reg. Dist. No.

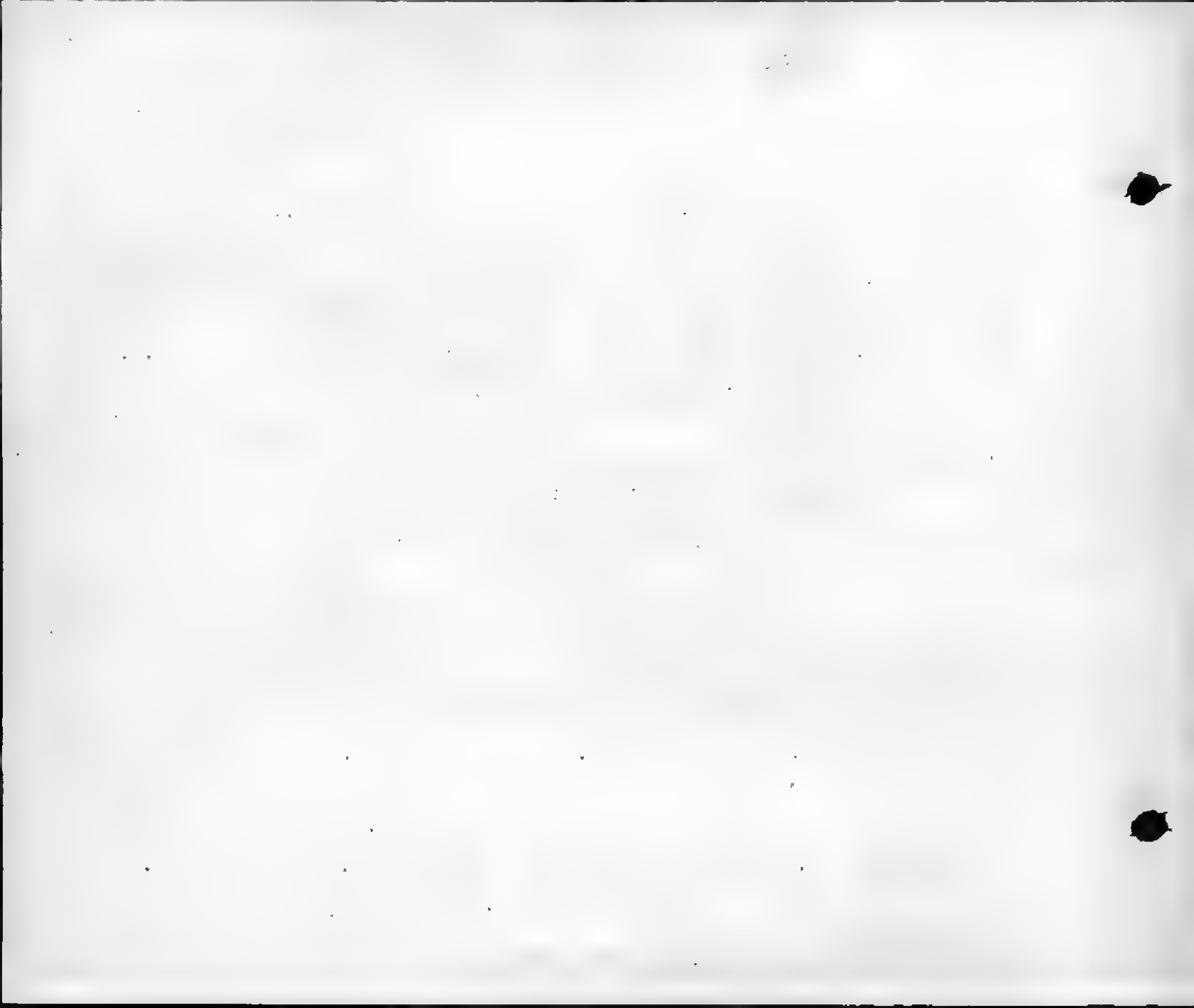
13241

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>94 Franklin St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Steve</b> Middle <b>FOUNDAS</b> Last <b>FOUNDAS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAR DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Apostolas Foundas</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>TW 1</b>	
17. INFORMANT <b>Artemis P. Characklis</b>		Address <b>35 Franklin St Annapolis, Md</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4:00</b> DUE TO		<b>1 month</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO		<b>1 year</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 22, 1959</b> , to <b>Dec. 21, 1959</b> , that I last saw the deceased alive on <b>Dec. 21, 1959</b> , and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Martin</b>		ADDRESS (Street, city or town, state) <b>6 Shaw St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		DATE SIGNED <b>12/22/59</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13282

## CERTIFICATE OF DEATH

Reg. Dist. No.

13242

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>18 days</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Unknown</b> b. COUNTY <b>Charles</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <b>Hillary</b> Middle <b>Montgomery</b> Last <b>Frederick</b>				4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>19 59</b>				5. SEX <b>Male</b>				6. COLOR OR RACE <b>Negro</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ?? DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1900</b>				9. AGE (In years lost birthday) yrs. <b>59</b>				10. IF UNDER 1 YEAR Months <b>59</b>				11. IF UNDER 24 HRS Hours <b>59</b>				12. IF UNDER 24 HRS Min. <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>				11. BIRTHPLACE (State or foreign country) <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Isaac Frederick</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>				INFORMANT <b>Hospital Records</b>				Address																											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]																INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>																																							
DUE TO																																							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.																																							
DUE TO																																							
DUE TO																																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
<b>Arteriosclerotic Cardiovascular Disease</b>																																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --																20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>---</b>								20f. (City or town) (County) (State) <b>---</b>							
21. I certify that I attended the deceased from <b>12/5</b> , 19 <b>59</b> to <b>12/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/23</b> , 19 <b>59</b> and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above.																																							
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>																ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>								DATE SIGNED <b>12/23/59</b>															
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>																<b>Crownsville State Hospital, Md.</b>								<b>12/23/59</b>															
22a. BURIAL, CREMAT., ON, REMOVAL (Specify)				22b. DATE THEREOF <b>12-29-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>																											
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carmichael Matthews</b>																ADDRESS <b>2619-14th St. NW</b>				24a. REC'D BY REGISTRAR <b>DATE DEC 28 59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

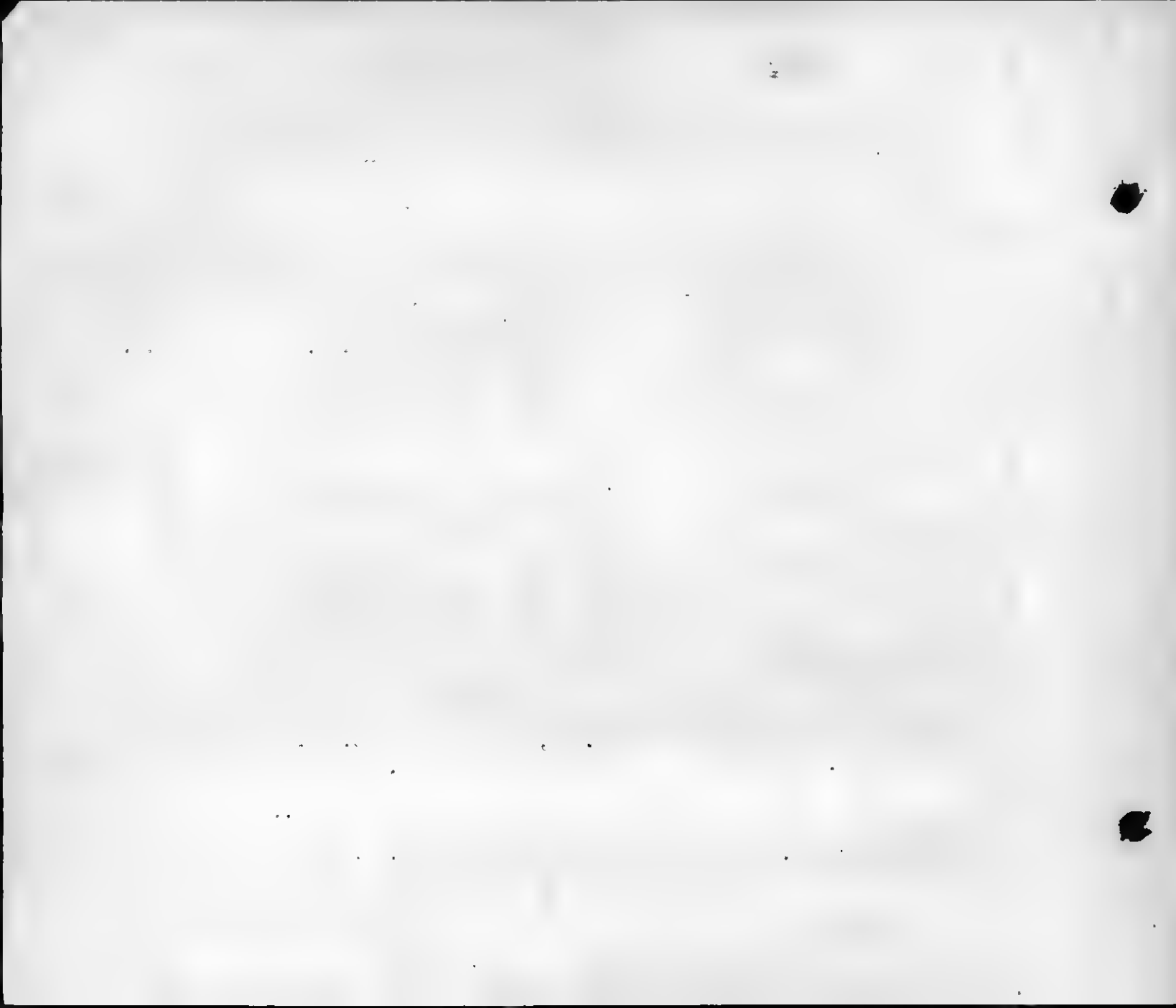
13243

13243

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>1½ months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Box-54</b>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>S</b> Last <b>FRENCH</b>				4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 30, 1895</b>	
9. AGE (In years last birthday) <b>64 yrs</b>		IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William J. Davidson</b>				14. MOTHER'S MAIDEN NAME <b>Florence Lloyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gerard Neumann</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of sigmoid colon</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>1959</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Nov. 11, 1959</b> , to <b>Dec. 29, 1959</b> , that I last saw the deceased alive on <b>Dec. 29, 1959</b> , and that death occurred at <b>2:20 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>98 Cathedral St., Annapolis, Maryland</b> DATE SIGNED <b>12/30/59</b>							
ACTUAL SIGNATURE <b>Jesse L. Wilkins</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Jesse L. Wilkins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, and county) (State)	
<b>Cremation</b>		<b>1-2-1960</b>		<b>Ft Lincoln Cent</b>		<b>Prince Geo Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR <b>DAWN 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13283

## CERTIFICATE OF DEATH

Reg. Dist. No.

13244

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 500 Rd #5 Pasadena P.O. Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlotte Curtis Fry</u> First Middle Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14, 1873</u> 86 yrs.
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reoand Porter Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Travis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>P.R. Fry - Box 500, Rd #5 Pasadena P.O. Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>153.0</u> DUE TO (b) <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Carcinoma Ascending Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 m m</u> <u>7 mos</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 7</u> , 19 <u>49</u> to <u>Dec 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>59</u> , and that death occurred at <u>3:47</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Prichard</u> M.D.		DATE SIGNED <u>12/29/59</u>	
PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 31 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Phila Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Chester Co Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13244

## CERTIFICATE OF DEATH

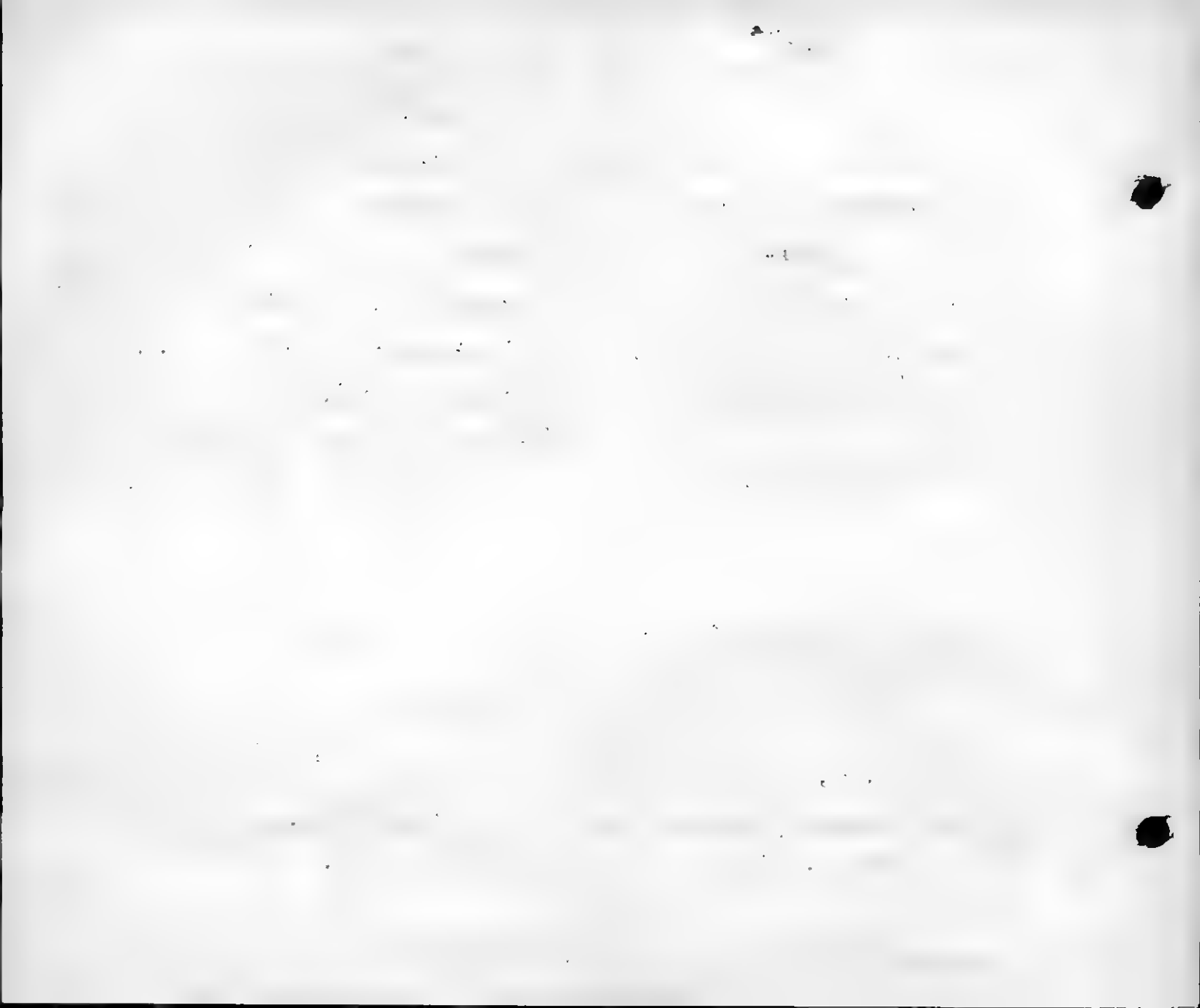
13245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arlene</u> Middle <u>FULTON</u> Last <u>FULTON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 9, 1895</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Baker, Maryland KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
13. FATHER'S NAME <u>Dr. W. B. LITTREAR</u>				14. MOTHER'S MAIDEN NAME <u>ROSE HARDIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>George T. Fulton</u>				Address <u>43 Lake Drive Bay Ridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension due to 1 1/2 yrs therapy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>October</u> , 1956, to <u>Dec. 27</u> , 1959, that I last saw the deceased alive on <u>Dec. 27</u> , 1959, and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St.,</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				DATE SIGNED <u>12/28/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 13246

13245

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>152 Williams Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nathaniel</u> Middle <u>G</u> Last <u>Gates</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 15, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Boat Supply</u>		11. BIRTHPLACE (State or foreign country) <u>Pridgeton, New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathaniel Gates, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bateman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>220-16-9017</u>		17. INFORMANT <u>Harvey E. Gates- Son- Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>cardiac disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO <u>arteriosclerosis</u> (c) <u></u> DUE TO <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiac disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>12/24</u> 19 <u>59</u> to <u>12/24</u> 19 <u>59</u> that I last saw the deceased alive on <u>12/24</u> 19 <u>59</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST. ANNAPOLIS MD</u>				DATE SIGNED <u>12/24/59</u>			
ACTUAL SIGNATURE <u>Richard N. Baker</u>				M.D. <u>ANNAPOLIS MD</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD N. BAKER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 27 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13284

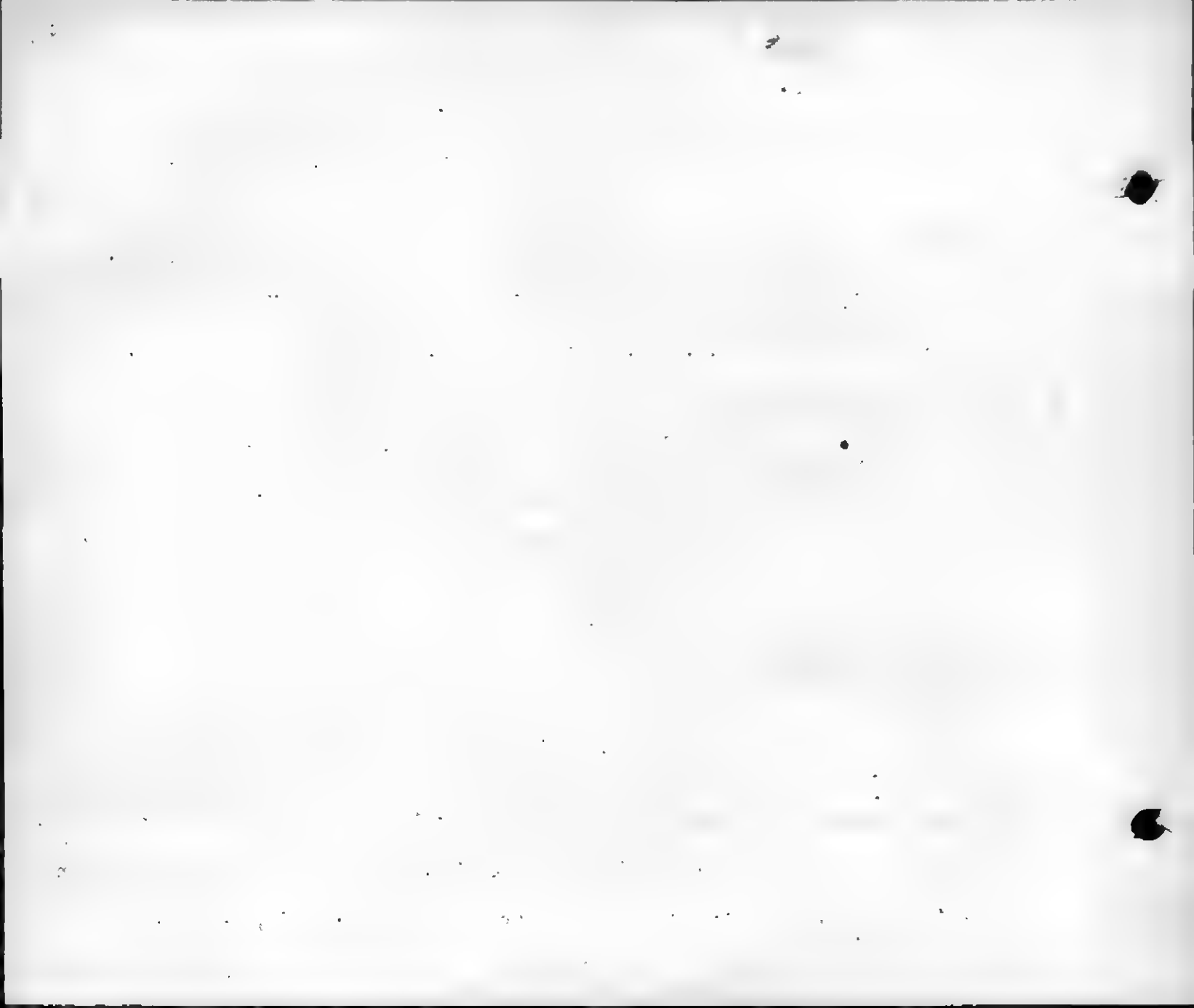
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rt 1 Annapolis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rt. 1 Annapolis</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) First Middle Last <b>RALPH EDWARD GOUL</b>		4. DATE OF DEATH Month Day Year <b>December 8, 1959 19</b>							
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1906</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov. Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Ka.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James Madison Goul</b>		14. MOTHER'S MAIDEN NAME <b>Grace E Young</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>533 10 0130</b>		INFORMANT <b>Mrs. Margaret L. Goul- Wife- Same as # 2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myeloma with generalized metastases</b> DUE TO (b) <b>Metastases</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b> <b>1 m 24 d</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-19</b> , 19 <b>57</b> to <b>12-8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-6</b> , 19 <b>59</b> , and that death occurred at <b>10:30 A.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>45 Franklin St. Annapolis Md.</b>		DATE SIGNED <b>Edith Rodler M.D.</b>					
ACTUAL SIGNATURE <b>Edith Rodler</b>		PHYSICIAN'S NAME (Type) <b>Edith Rodler MD</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>Dec. 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

13283

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

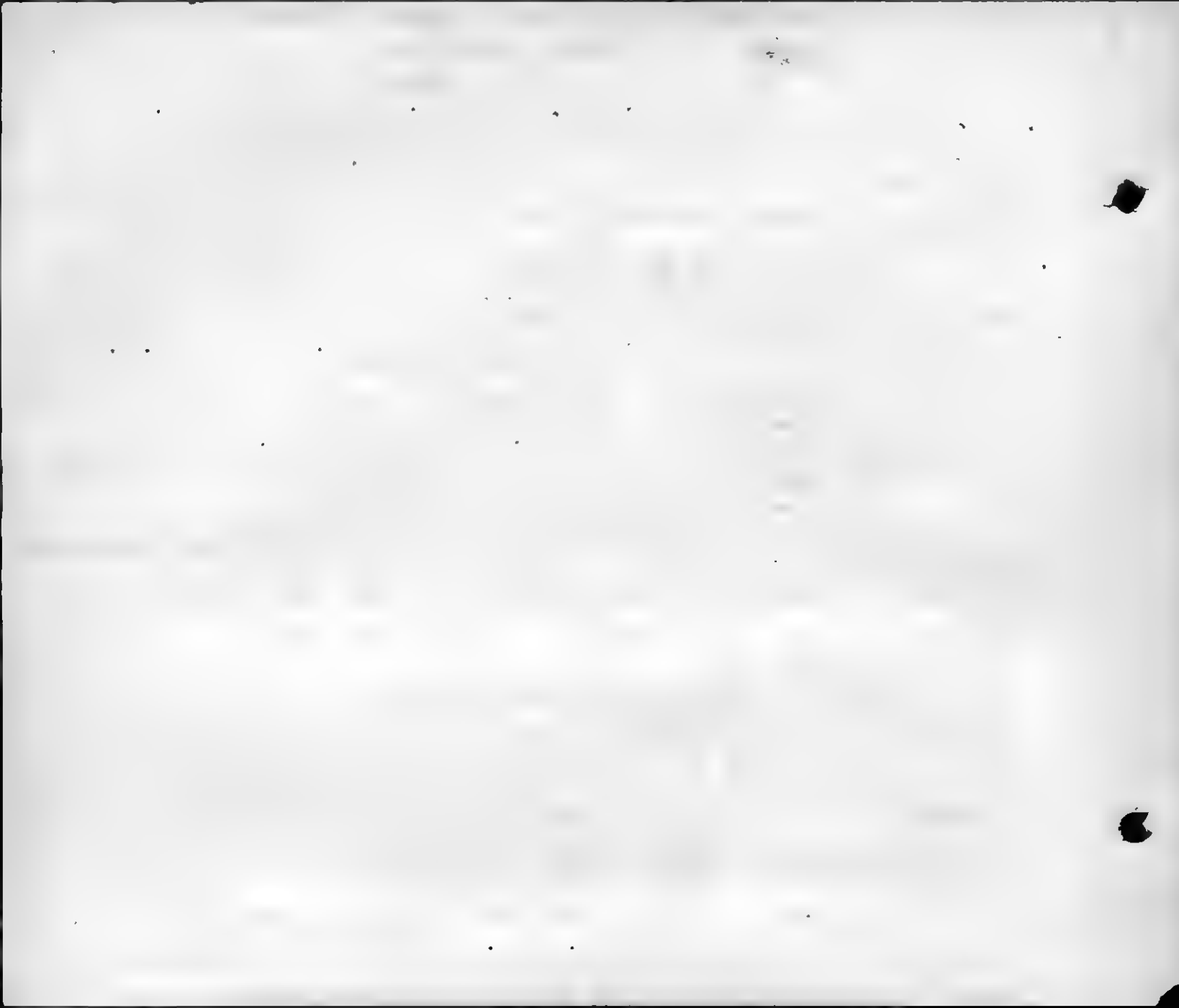
Reg. Dist. No.

13249

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 10, Box 50, Lakeshore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena, Md.</u>			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>LOUISE</u> Last <u>GRANGER</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1899</u>	9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Detzel</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Kolhoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Robert Pritchard, Rt. 10, Box 50, Pasadena</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>							
443X DUE TO <u>Hypertensive Cardiovascular</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 25, 1959</u> to <u>Dec. 2, 1959</u> , that I last saw the deceased alive on <u>Dec. 1, 1959</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>2101 South Ritchie Hwy, Md.</u>				DATE SIGNED <u>Dec 2, 1959</u>			
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u>							
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>				<u>Glen Burnie, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FLYNN &amp; FLEMING, INC. 1422 Light St. Balto.30</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13286

## CERTIFICATE OF DEATH

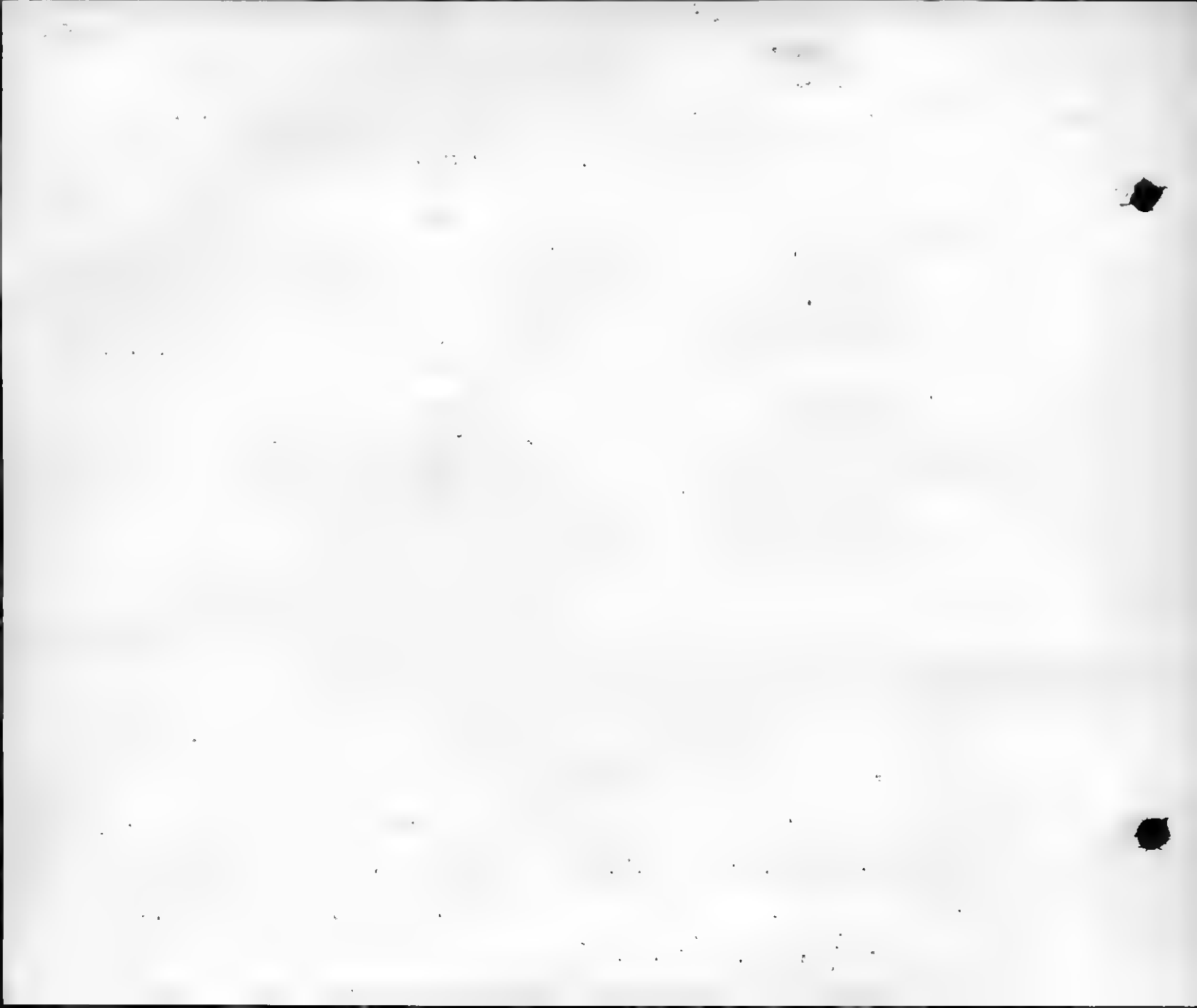
Reg. Dist. No.

13250

1. PLACE OF DEATH a. COUNTY <b>Severn - Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. LENGTH OF STAY IN 1b <b>85 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Ann Griffith</b>		4. DATE OF DEATH Month Day Year <b>December 1 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1874</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua Stinchcomb</b>		14. MOTHER'S MAIDEN NAME <b>Louise Ann Boyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <b>Miss Hildreth Griffith, same as 2</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis &amp; Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 mo.</b> <b>10-14 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1947</b> to <b>12/1/59</b> , 19____, that I last saw the deceased alive on <b>12/1/59</b> , 19____, and that death occurred at <b>4:14 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles L. Ball Jr.</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Linthicum Md. 12/3/59</b>	
PHYSICIAN'S NAME (Type) <b>Charles L. Ball, M.D.</b>		<b>Linthicum, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1 <sup>d</sup> STREET ADDRESS <i>201 Church St.</i>	
3. NAME OF DECEASED (Type or print) First <i>ALBERTINA</i> Middle <i>HAEGERICH</i> Last		4. DATE OF DEATH Month <i>12</i> - Day <i>15</i> - Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-7-80</i>
9. AGE (In years lost birthday) <i>79</i> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Koenig</i>		14. MOTHER'S MAIDEN NAME <i>Clara</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>-</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Arteriosclerotic general</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May</i> , 19 <i>57</i> , to <i>Dec 15</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 10</i> , 19 <i>59</i> , and that death occurred at <i>12:30 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Taler, M.D.</i>		ADDRESS (Street, city or town, state) <i>102 Bd A Bldg. N.E.</i> DATE SIGNED <i>12-16-59</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH TALER Glen Burnie, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London PK</i>	22d. LOCATION (City, town, or county) (State) <i>Sett.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i> ADDRESS <i>130 E. Fort Ave.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 18 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AD</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>201 Church St</i>		d. STREET ADDRESS <i>201 Church St</i>	
3. NAME OF DECEASED (Type or print) <i>G. William Haegerich</i> First Middle Last		4. DATE OF DEATH <i>12-20-59</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-78</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Electric Standard Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ret.</i>	11. BIRTHPLACE (State or foreign country) <i>MD.</i>
13. FATHER'S NAME <i>CHAS. W.</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH MAQUAAD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>N/O</i>		16. SOCIAL SECURITY NO. <i>111-111-1111</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Insufficiency</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 1955, to <i>12-20</i> , 1959, that I last saw the deceased alive on <i>12-19</i> , 1959, and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eugene Schmitz</i>		ADDRESS (Street, city or town, state) <i>3904 S Hanover St. Balto. 25, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schmitz</i>		DATE SIGNED <i>12-21-59</i>	
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>15</i>	22b. DATE THEREOF <i>12/22/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodson PK</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCarty</i>		ADDRESS <i>130 E Fort Ave</i>	
24a. REC'D BY REGISTRAR <i>DEC 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13289

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>11mo. 21 days</u>				d. STREET ADDRESS <u>1111 Wolfe Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie or William</u> First Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1900</u>	
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Lumber Mill</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Simeon Haywood</u>				14. MOTHER'S MAIDEN NAME <u>Louisiana</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> - <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>52</u> to <u>12/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>59</u> , and that death occurred at <u>8:05 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>			
DATE SIGNED <u>12/7/59</u>							
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				ADDRESS <u>Crownsville State Hospital, Md.</u>			
DATE SIGNED <u>12/7/59</u>							
22a. BURIAL: CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Pollock</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13246

## CERTIFICATE OF DEATH

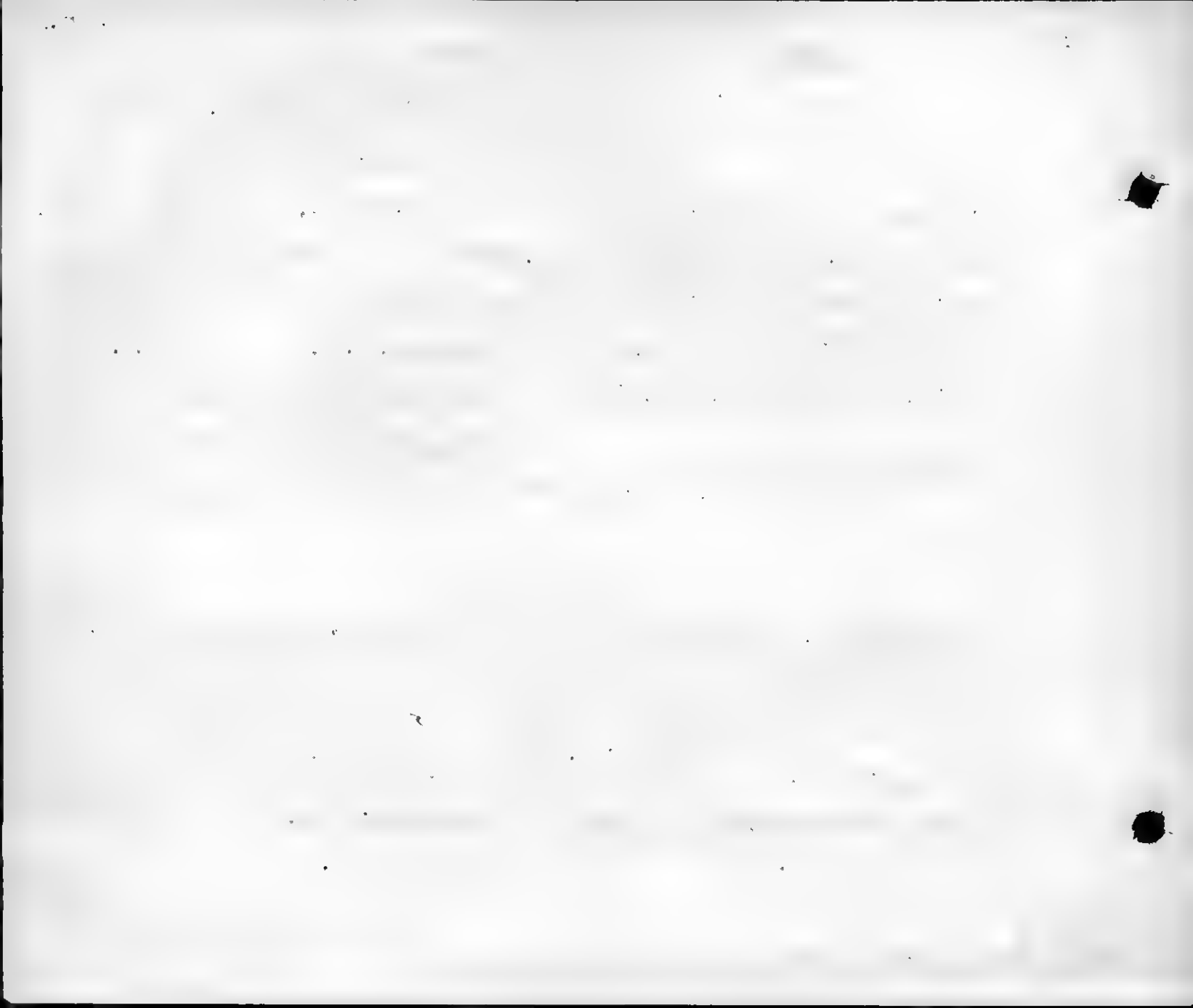
Reg. Dist. No.

13254

1. PLACE OF DEATH a. COUNTY <u>ANNE A. U. DEL</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>WARD</u> Last <u>HEADRICK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1923</u>
9. AGE (In years lost birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MERRICK G. ESTABROOK</u>		14. MOTHER'S MAIDEN NAME <u>MARION HARTLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY ABSCESS RIGHT UPPER LOBE</u> DUE TO <u>521X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLD HEADED PULMONARY TUBERCULOSIS EMACIATION</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Nov. 26, 1959</u> to <u>Dec. 15, 1959</u> that I lost saw the deceased alive on <u>Dec. 15, 1959</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave.,</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>		DATE SIGNED <u>12/16/59</u>	
22a. <del>BURIAL</del> CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>12-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>		24a. REG'D BY REGISTRAR <u>DEC 27 59</u>	
ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Orlando E. Howard</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13247

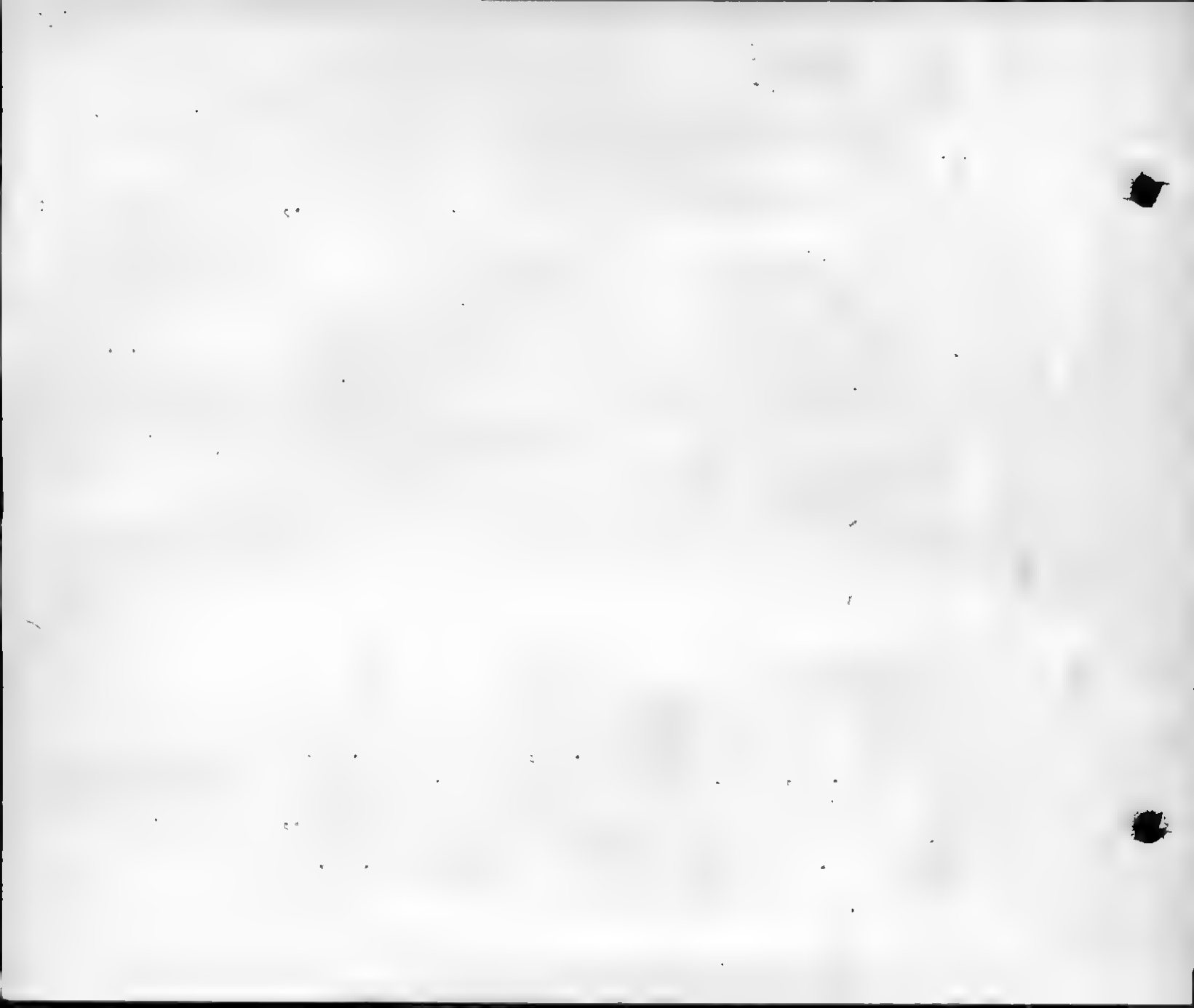
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elbert</b> Middle <b>HENSON</b> Last <b>HENSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1905</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Elyah Henson</b>		14. MOTHER'S MAIDEN NAME <b>Hertine Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-0697</b>	
17. INFORMANT <b>Bernard Henson 205 West St. Annapolis</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492x</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 15, 1959</b> , to <b>Dec. 15, 1959</b> , that I last saw the deceased alive on <b>Dec. 15, 1959</b> , and that death occurred <b>11:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aris T. Allen</b>		ADDRESS (Street, city or town, state) <b>62 Cathedral St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Aris T. Allen</b>		DATE SIGNED <b>12/16/59</b>	
22a. BURIAL, CREMATORY, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Henson</b>	22d. LOCATION (City, town, or county) (State) <b>St. Margarets, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '59</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

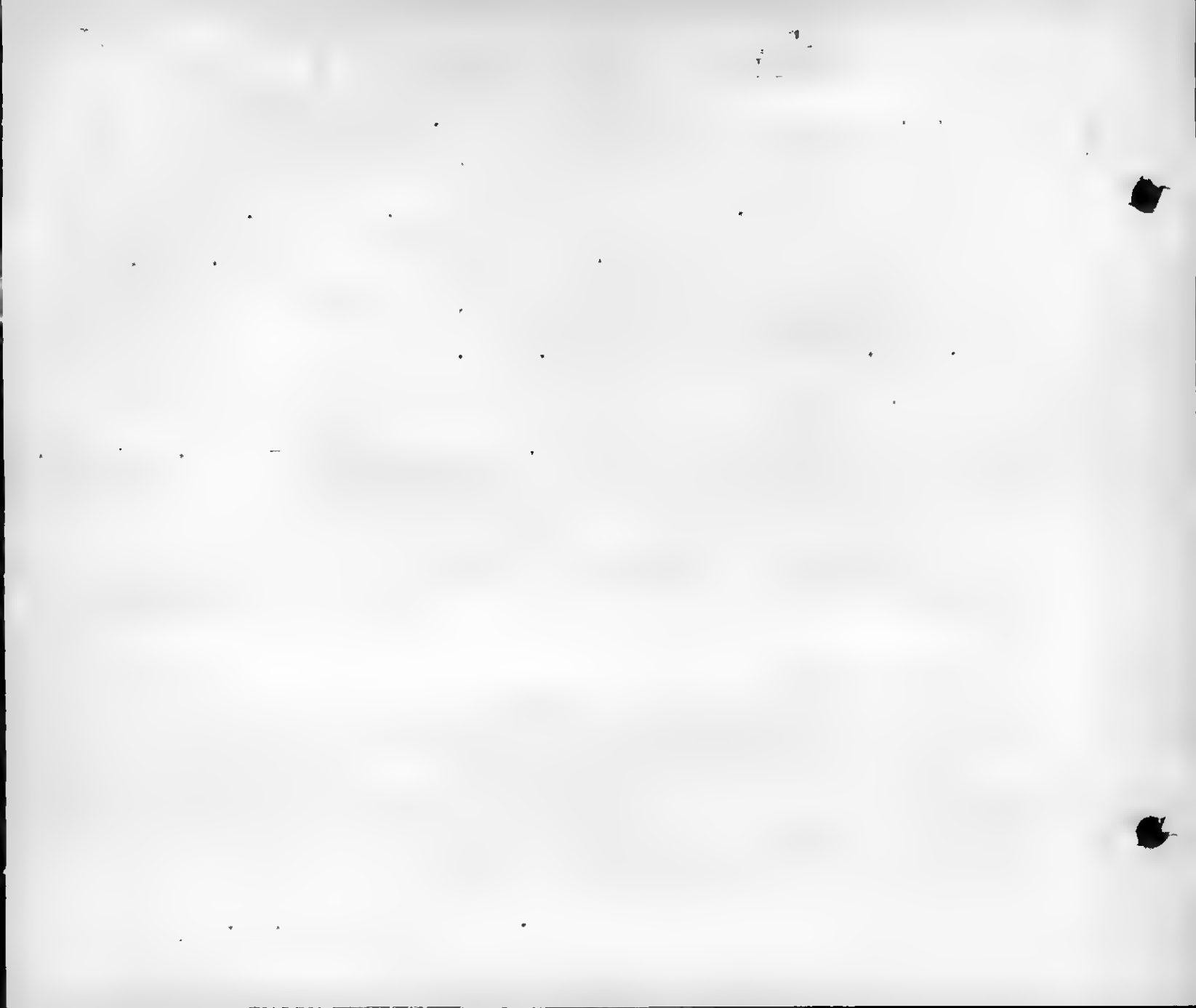
13248

## CERTIFICATE OF DEATH

13256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 1 mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
3. NAME OF DECEASED (Type or print) <b>WILLIAM F. HILGENBERG</b>		4. DATE OF DEATH Month <b>Dec.</b>		Day <b>22,</b>		Year <b>19 59</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1903</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pres. Treas.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaboard Fish Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William F. Hilgenberg</b>		14. MOTHER'S MAIDEN NAME <b>Rose Marie Hilgenberg</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Caroline Hilgenberg - 3700 N. Charles St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>1 day</b> <b>?</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>19 54</b> to <b>Dec 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 24</b> , 19 <b>59</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <b>Sylvan D. Goldberg</b>		M.D. <b>Michael A. Berg</b>		ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>		PHYSICIAN'S NAME (Type) <b>Baltimore, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Liskner</b>		ADDRESS <b>4401 E. Baltimore Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





13290

## CERTIFICATE OF DEATH

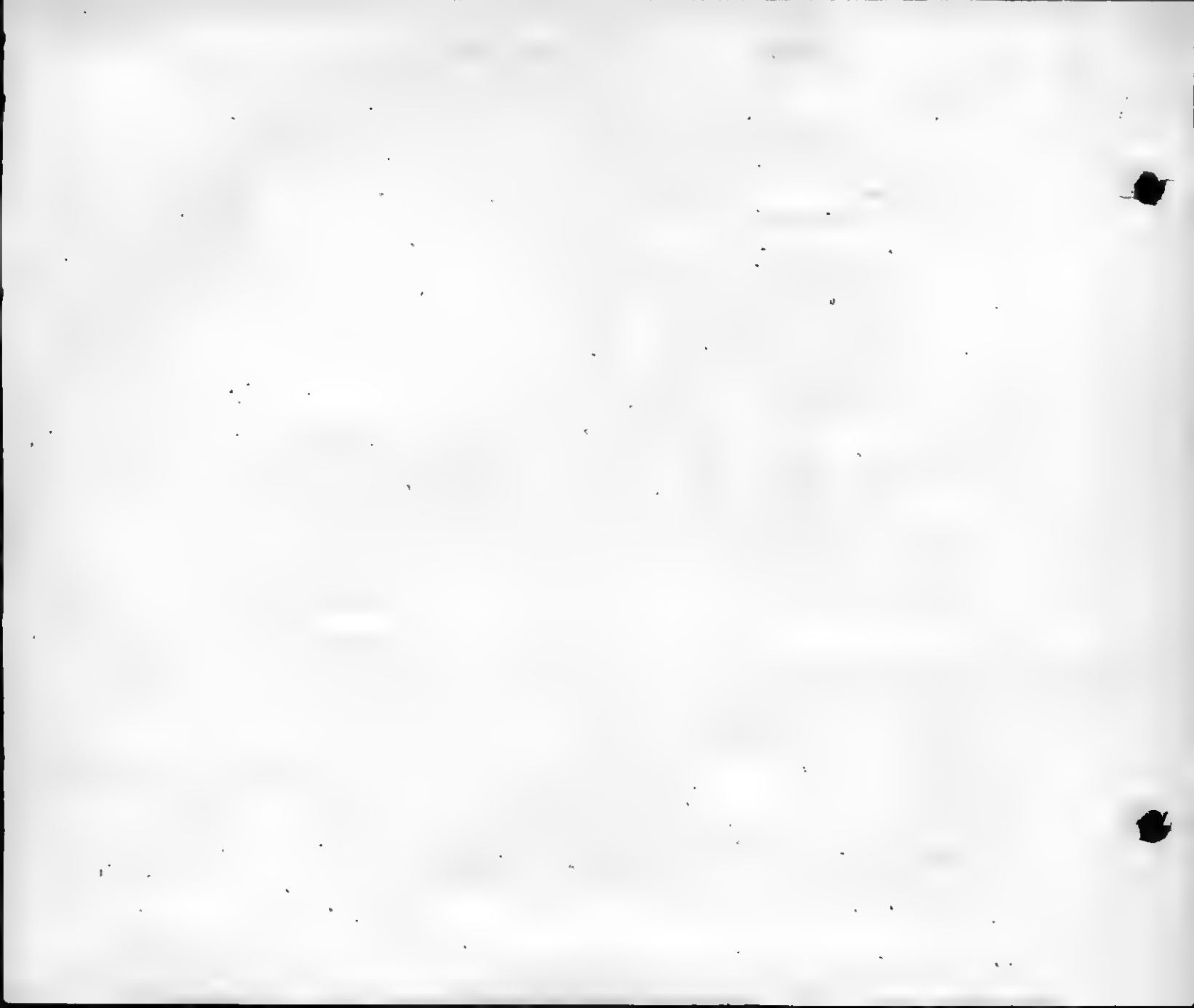
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 3. Edgewood Rd.</u>		d. STREET ADDRESS <u>Rt. 3. Edgewood Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joshua</u> First <u>Holladay</u> Middle <u>Holladay</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1887</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. families</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Holladay</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jean Gross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-158837</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Head</u> 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/30/57</u> , 19 <u>57</u> , to <u>12/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson</u>		<u>320 Calvert St. Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-5-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William K. Little</u> ADDRESS <u>1105 South St. Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

13258

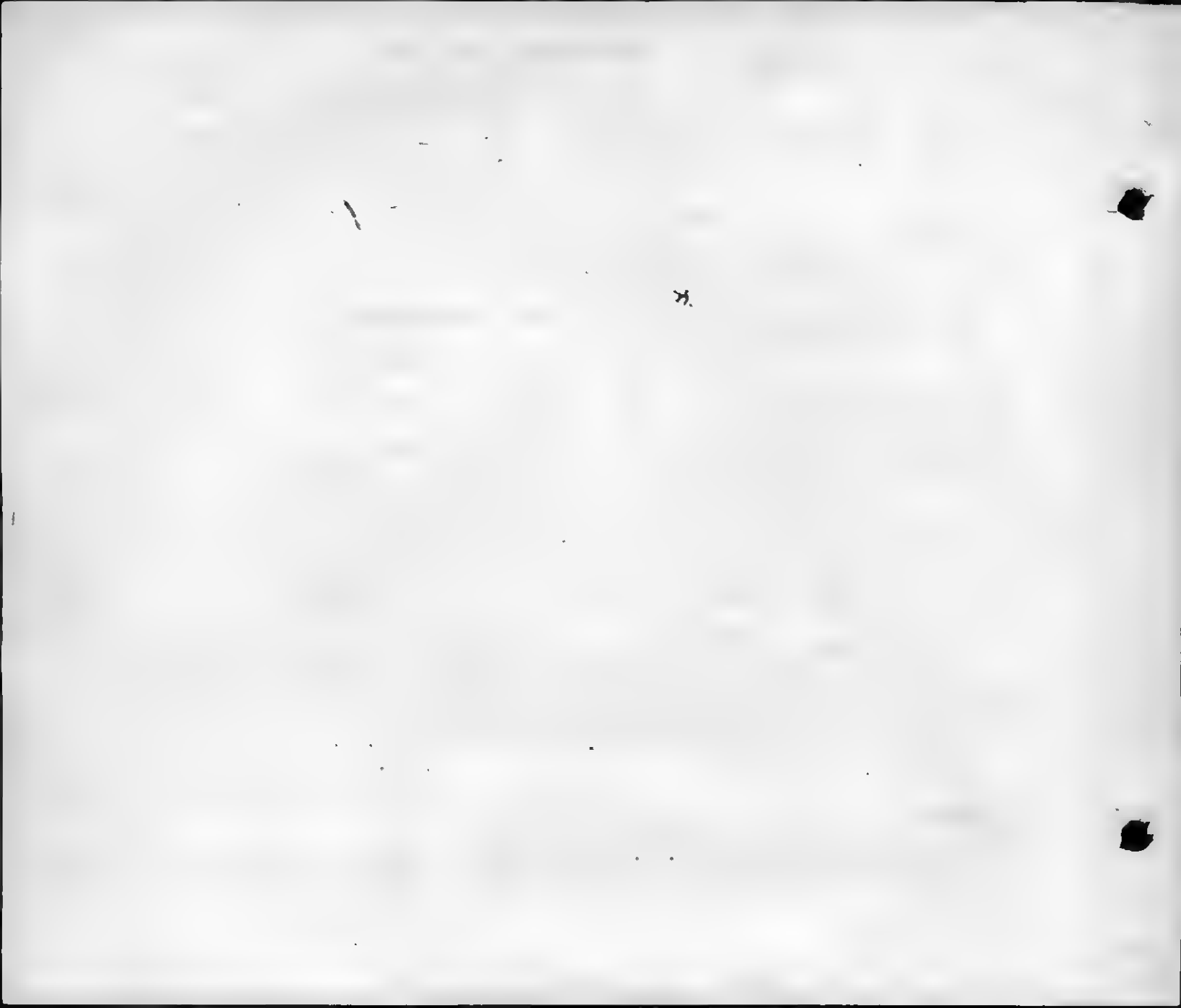
Reg. Dist. No.

13291

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>UNKNOWN</u> b. COUNTY <u>UNKNOWN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>				c. LENGTH OF STAY IN lb <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO, Md.</u>			
				f. STREET ADDRESS <u>1716 Beryl Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Holmes</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898</u>		9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>526 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis, bilateral</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 10,</u> 19 <u>59</u> , to <u>Dec. 1,</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 1,</u> 19 <u>59</u> , and that death occurred at <u>6:05A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D., Crownsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. CEM.</u>		22d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malcolm E. Calverton</u>				ADDRESS <u>1129 N. Caroline St.</u>		24a. REC'D BY REGISTRAR <u>DEC 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

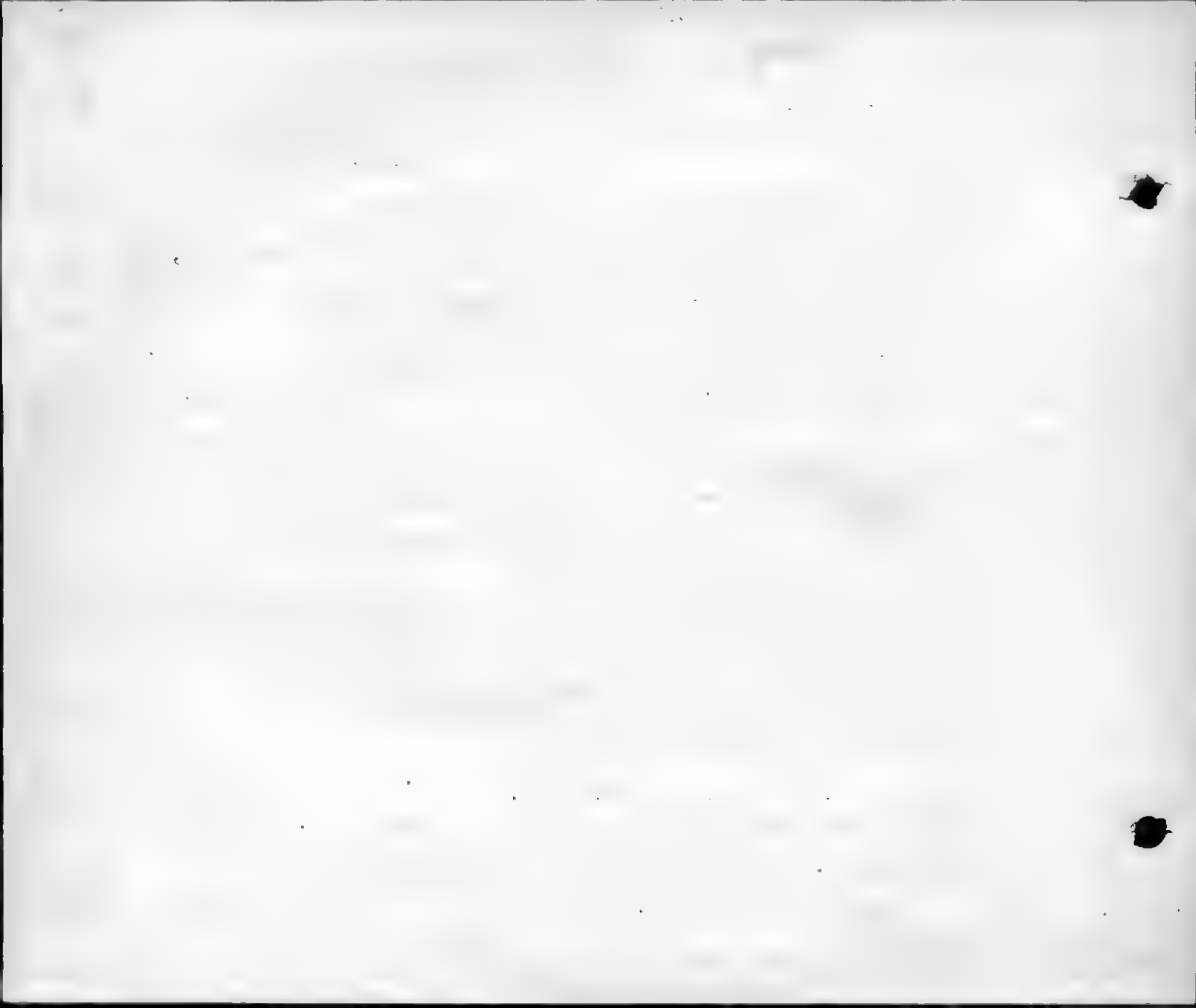
13249

## CERTIFICATE OF DEATH

Reg. Dist. No. 13259

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 097 Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha HOWE		4. DATE OF DEATH Month Day Year December 27, 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Chisels		14. MOTHER'S MAIDEN NAME Elsie Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 212-36-7072	
17. ADDRESS 827 Spa Road		INFORMANT Viola Brown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4:11 Coronary occlusion DUE TO (b) Aortic stenosis DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 097 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27, 1959, to 12-27-59, that I last saw the deceased alive on 12, and that death occurred on 2 N. M. from the causes and on the date stated above. Dead on arrival at hospital in ambulance. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank M. Shipley M.D. 121 Cathedral St., 12/28/59 PHYSICIAN'S NAME (Type) Frank M. Shipley Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #11111111		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13250

## CERTIFICATE OF DEATH

13260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis Gen. Hosp.</u>				1 d. STREET ADDRESS <u>8205 FT. SMALLWOOD Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>ESTHER A.</u> Middle <u>HUNLEY</u> Last <u></u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Winkel</u>				14. MOTHER'S MAIDEN NAME <u>Annie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; pulmonary embolism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 15</u> , 19 <u>59</u> , to <u>Dec. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 24</u> , 19 <u>59</u> , and that death occurred at <u>9:45</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hedeman</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>		DATE SIGNED <u>12/25/59</u>	
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Newer Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Olden Burial, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>				ADDRESS <u>130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles J. Howard</u>			

457-1215

TO HOSPITAL  
may be retained

ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/85



13251

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>AA General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>M.</i> Last <i>Gray</i>		4. DATE OF DEATH Month <i>12</i> - Day <i>10</i> - Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-25-1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR: Months <i>66</i> Days <i>66</i> Hours <i>66</i> Min <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas L. Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Helen Marshall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>James T Gray</i>	
17. INFORMANT <i>(2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19 <i>12/10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/7</i> , 19 <i>59</i> , and that death occurred at <i>8:30</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) <i>[Signature]</i>	
PHYSICIAN'S NAME (Type) <i>F. L. Whitehead</i>		DATE SIGNED <i>12/10/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-13-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Curtis E. Howard</i>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13263

13292

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). b. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>05X</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Jones</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>&amp;</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u> 1898
9. AGE (In years last birthday) <u>62?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). ----- 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Dec. 28</u> , 19 <u>59</u> , to <u>Dec. 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 30</u> , 19 <u>59</u> , and that death occurred at <u>1:15 P</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hildegard Heard Reissman</u> M.D. <u>Crownsville State Hospital, Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JAN. 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill, Federalsburg</u>	22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Caroline Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton &amp; Son</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



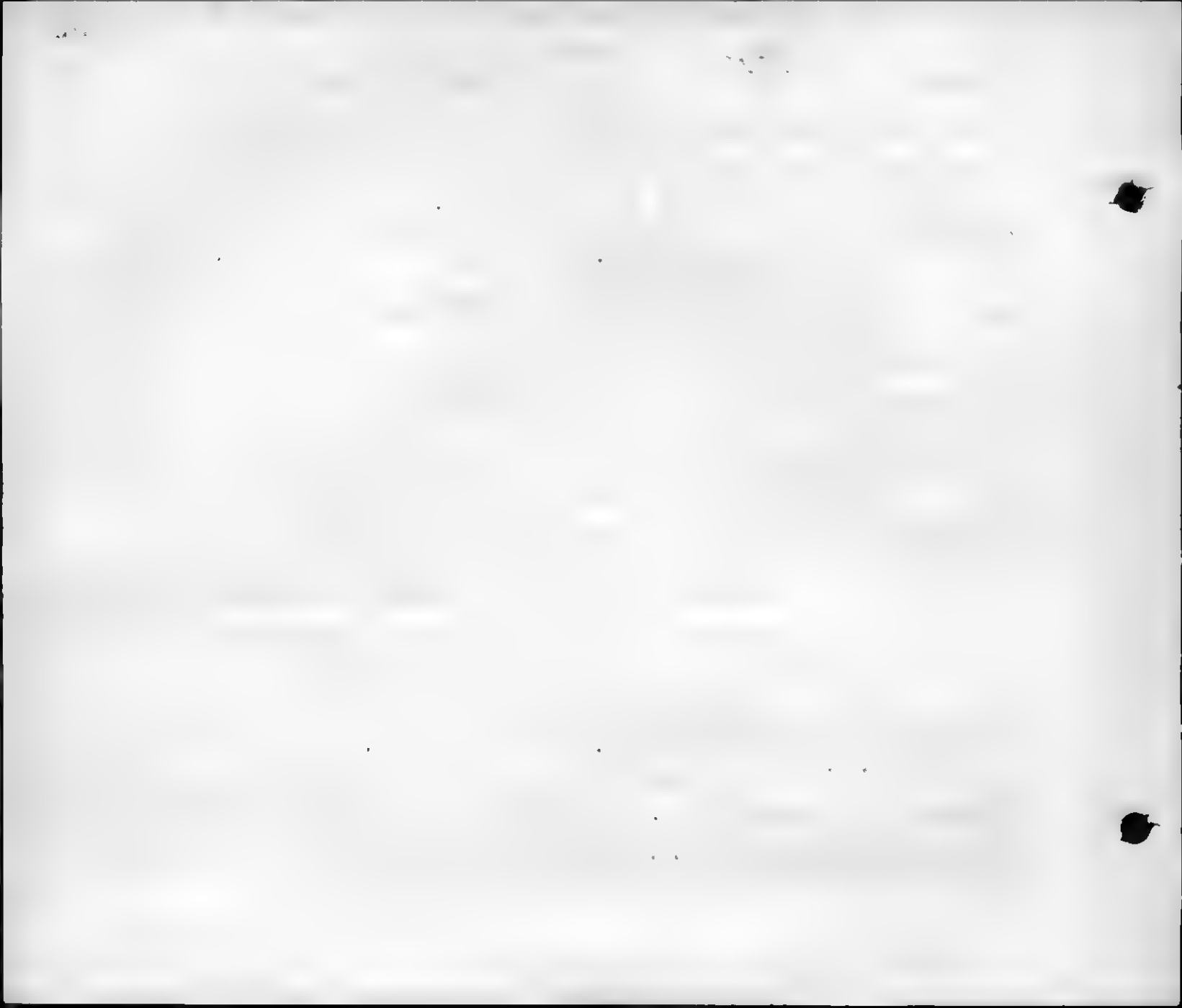
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville Maryland</u>				c. LENGTH OF STAY IN 1b <u>7mo. &amp; 3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>522 W. Lanville Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>		9. AGE (In years last birthday) <u>75?</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr. 27,</u> 19 <u>59,</u> to <u>Dec. 1,</u> 19 <u>59,</u> that I last saw the deceased alive on <u>Dec. 1,</u> 19 <u>59,</u> and that death occurred at <u>2:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M.D., Crownsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holstead-March</u> ADDRESS <u>918 David Hill Ave.</u>				24a. REC'D BY REGISTRAR <u>DEC 7 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL by the attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

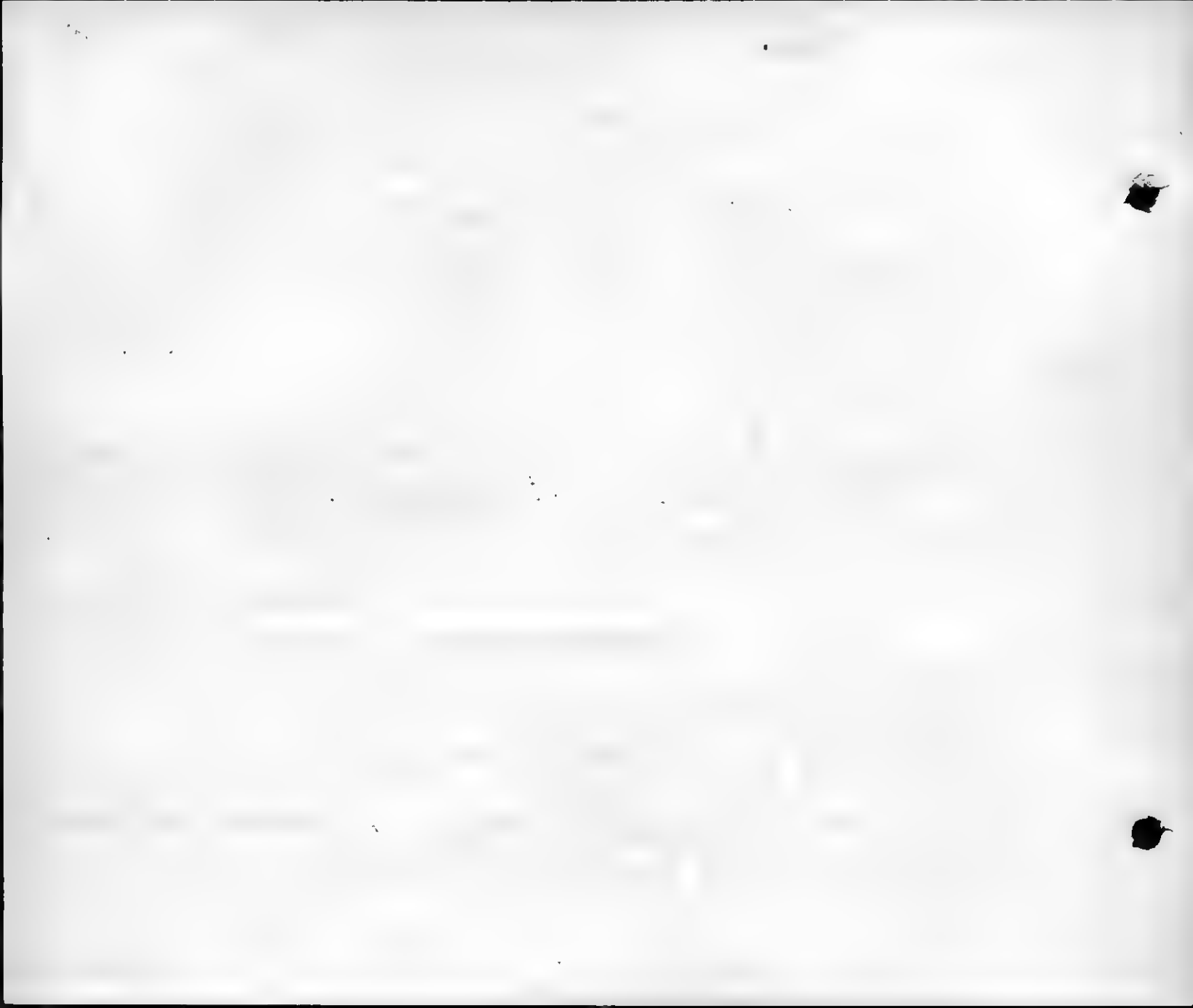
VS A15 (4)  
15M 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13294  
CERTIFICATE OF DEATH

13265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 540 Route 7, Lyndale Road</b>		d. STREET ADDRESS <b>Box 540 Route 7, Lyndale Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>FLORENCE</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>December</b> Day <b>13,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Zink</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Henry Schaefer Box 540 Route 7, Pasadena, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Acute bronchopneumonia - 2 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute bronchopneumonia - 2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1, 1958</b> to <b>December 13, 1959</b> , that I last saw the deceased alive on <b>December 12, 1959</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.M. McLaughlin</b>		ADDRESS (Street, city or town, state) <b>RFD 8 Box 44 - Pasadena, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>		DATE SIGNED <b>Dec 13, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road.</b>		24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

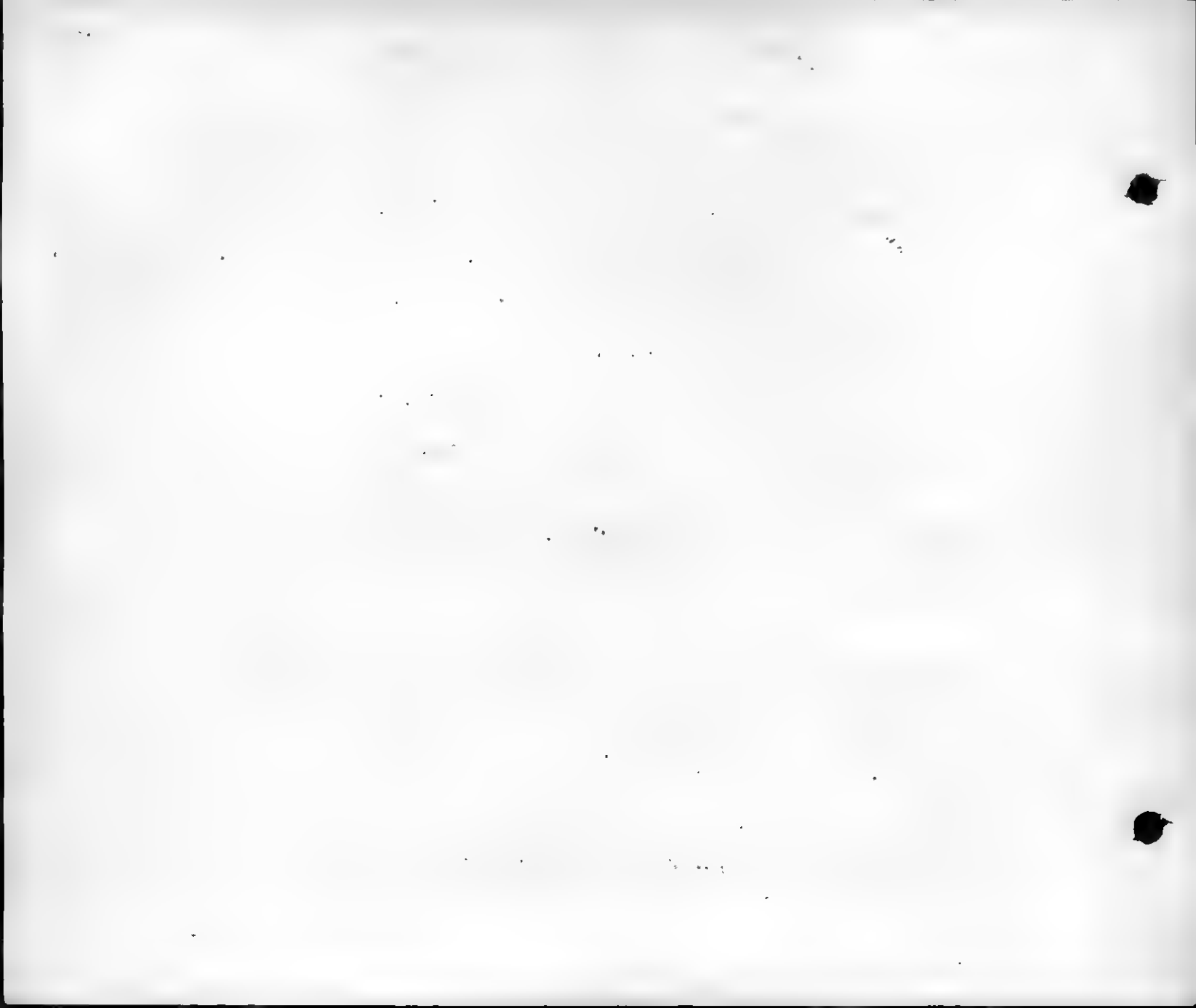
13295

## CERTIFICATE OF DEATH

Reg. Dist. No.

13266

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>				c. LENGTH OF STAY IN 1b <b>20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Jordan</b> Last <b>Jordan</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 12, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>Mose Jordan</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Jordan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>217-09-2223</b>		INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Glomerulosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 13, 1959</b> , to <b>Dec. 3, 1959</b> , that I last saw the deceased alive on <b>Dec. 3, 1959</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ludwig Benedict</i>				ADDRESS (Street, city or town, state) <b>M.D. Crownsville, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M.D.</b>				DATE SIGNED <b>Dec 7 '59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George S. Nelson</i>				ADDRESS <b>1348 N. Calhoun St</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13267

Reg. Dist. No.

13252

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A.A. Co.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN ID <u>WOODLAND BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>Box 307 Edgewater</u>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Harold</u> Last <u>Kuisley</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>21</u> Year <u>1959</u>							
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>10-12-1912</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ROUTE SALESMAN</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>GREEN SPRING DAIRY</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>							
<b>13. FATHER'S NAME</b> <u>"UNK"</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>GRETA WOOD</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1942-1945</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-14-6665</u>		<b>17. INFORMANT</b> <u>MARGARET KUISLEY</u> Address <u>#2</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcium Poisoning</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>E. Linhart</u> NAME (Type)		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>12-24-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>U.S. NATIONAL</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor</u>		<b>ADDRESS</b> <u>Annapolis, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 28 '59</u>							
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>DATE SIGNED</b> <u>12/24/59</u>									

MEDICAL CERTIFICATION

063

1

2

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13296

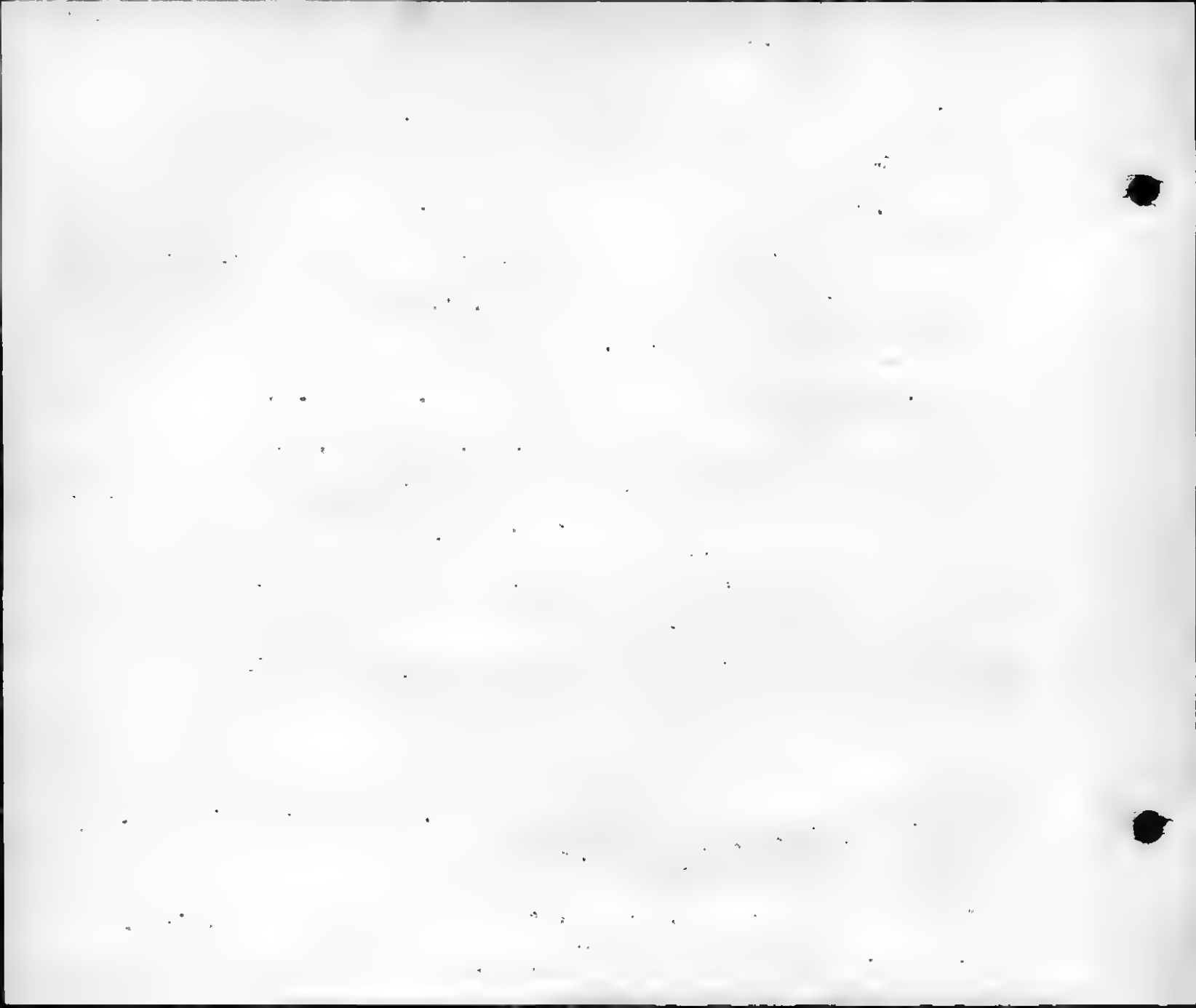
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>		c. LENGTH OF STAY IN 1b <b>8 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PO Box 5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Lipe</b> Last <b>Lipe</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1875</b>
9. AGE (In years last birthday) yrs <b>84</b>		IF UNDER 1 YEAR: Months <b>8</b> Days <b>17</b> Hours <b>3</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Griffith Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Matilda Harold</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>	
16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Mr. Wm. Davidson, same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Bronchial Pneumonia</b> <b>420.1</b> DUE TO (b) <b>Cold or Viral Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9:15</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1959</b> to <b>Dec 17, 1959</b> , that I last saw the deceased alive on <b>Dec 17, 1959</b> , and that death occurred at <b>9:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. JOSEPH LIPSKEY</b> M.D.		ADDRESS (Street, city or town, state) <b>Odenton Md</b> DATE SIGNED <b>12/18/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. JOSEPH LIPSKEY</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>12/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Knox Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Rogersville, Tenn</b>		23. BURIAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13297

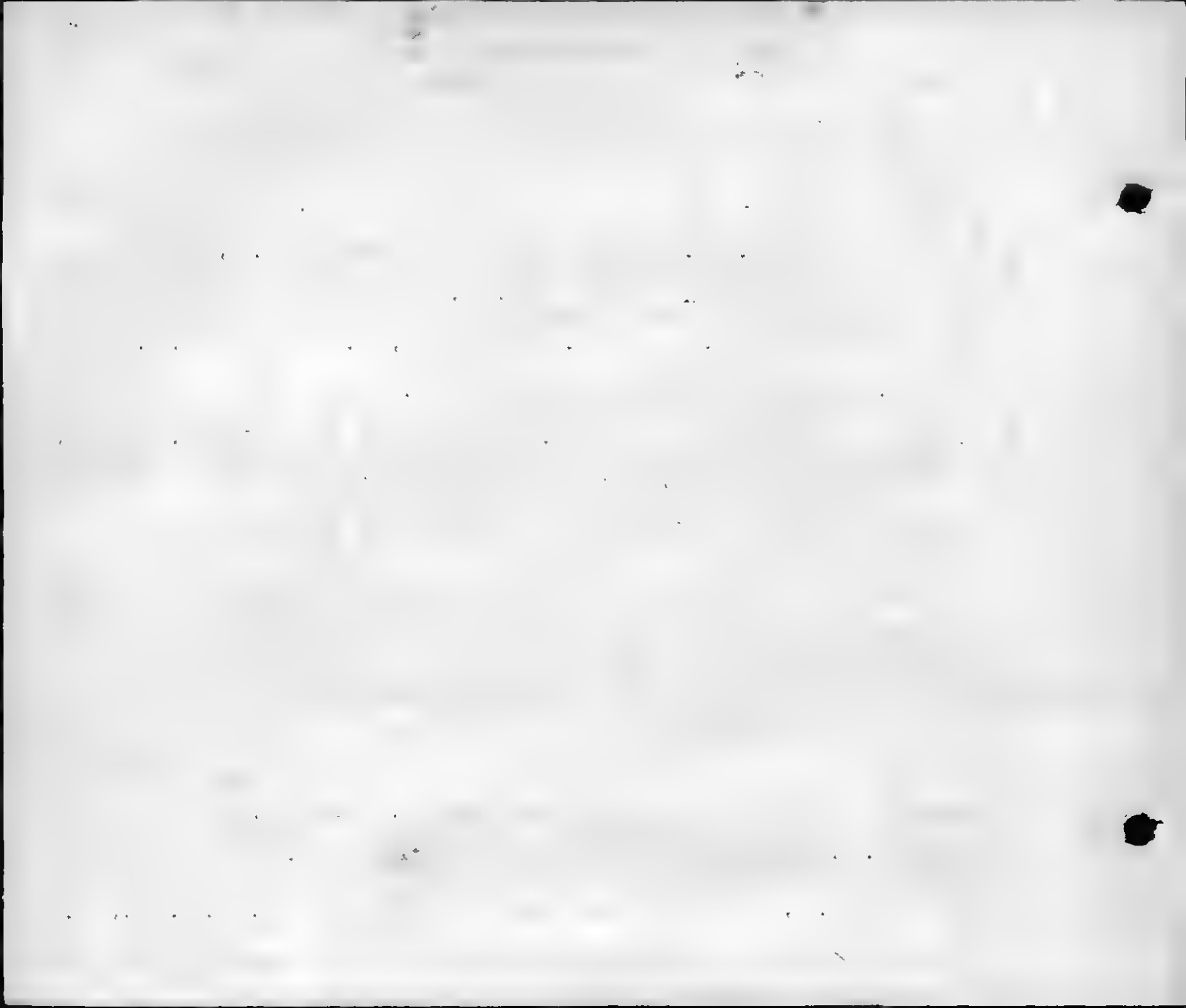
CERTIFICATE OF DEATH

Reg. Dist. No.

13269

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4103 Ritchie Highway</b>				d. STREET ADDRESS <b>4103 Ritchie Hwy.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>John J. Lipp</b>				4. DATE OF DEATH Month <b>Dec. 1, 1959</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1882</b>	9. AGE (In years last birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	IF UNDER 24 HRS Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Drydock Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John C. Lipp</b>				14. MOTHER'S MAIDEN NAME <b>Louise P. Krause</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. Ferdinand Lipp 200 Charles St. Bato 25, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1959</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1958</b> to <b>Jan 1, 1959</b> , that I last saw the deceased alive on <b>Jan 25, 1959</b> , and that death occurred at <b>8:00</b> M, from the cause, and on the date stated above. ADDRESS (Street, city or town, state) <b>1337 S. Charles St.</b> DATE SIGNED <b>John G. Scheurich</b>							
ACTUAL SIGNATURE <b>John G. Scheurich</b>				M.D. <b>1337 S. Charles St.</b>			
PHYSICIAN'S NAME (Type) <b>J. A. Scheurich</b>				Baltimore 30, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy. A. A. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Gorce</b>				ADDRESS <b>4001 Ritchie Hwy. (25)</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13298

## CERTIFICATE OF DEATH

Reg. Dist. No.

13270

## 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pasadena

c. LENGTH OF STAY IN 1b

88 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pasadena

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☐3. NAME OF DECEASED  
(Type or print)First Middle Last  
William A. Lowery

## 4. DATE OF DEATH

Month Day Year  
December 2 1959

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

December 5, 1870

## 9. AGE (In years lost birthday)

88 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Boat Builder

10b. KIND OF BUSINESS OR INDUSTRY

Self-Employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William James Lowery

## 14. MOTHER'S MAIDEN NAME

Alice Covington

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## INFORMANT

## Address

Mrs. Helen Robbins, same as 2

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

Arteriosclerotic Cardiovascular disease  
Cardiac decompensation

INTERVAL BETWEEN ONSET AND DEATH

2 weeks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

None

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month Day Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 30, 1950, to December 2, 1959, that I last saw the deceased alive on December 2, 1959, and that death occurred at 7:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE

R.M. McLaughlin

M.D.

ADDRESS (Street, city or town, state)

R.F.D. 8 Box 442 Pasadena, Md. Dec 2, 1959

DATE SIGNED

PHYSICIAN'S NAME (Type)

R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/5/59

22c. NAME OF CEMETERY OR CREMATORY

Mt. Carmel

22d. LOCATION (City, town, or county)

A.A. County

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

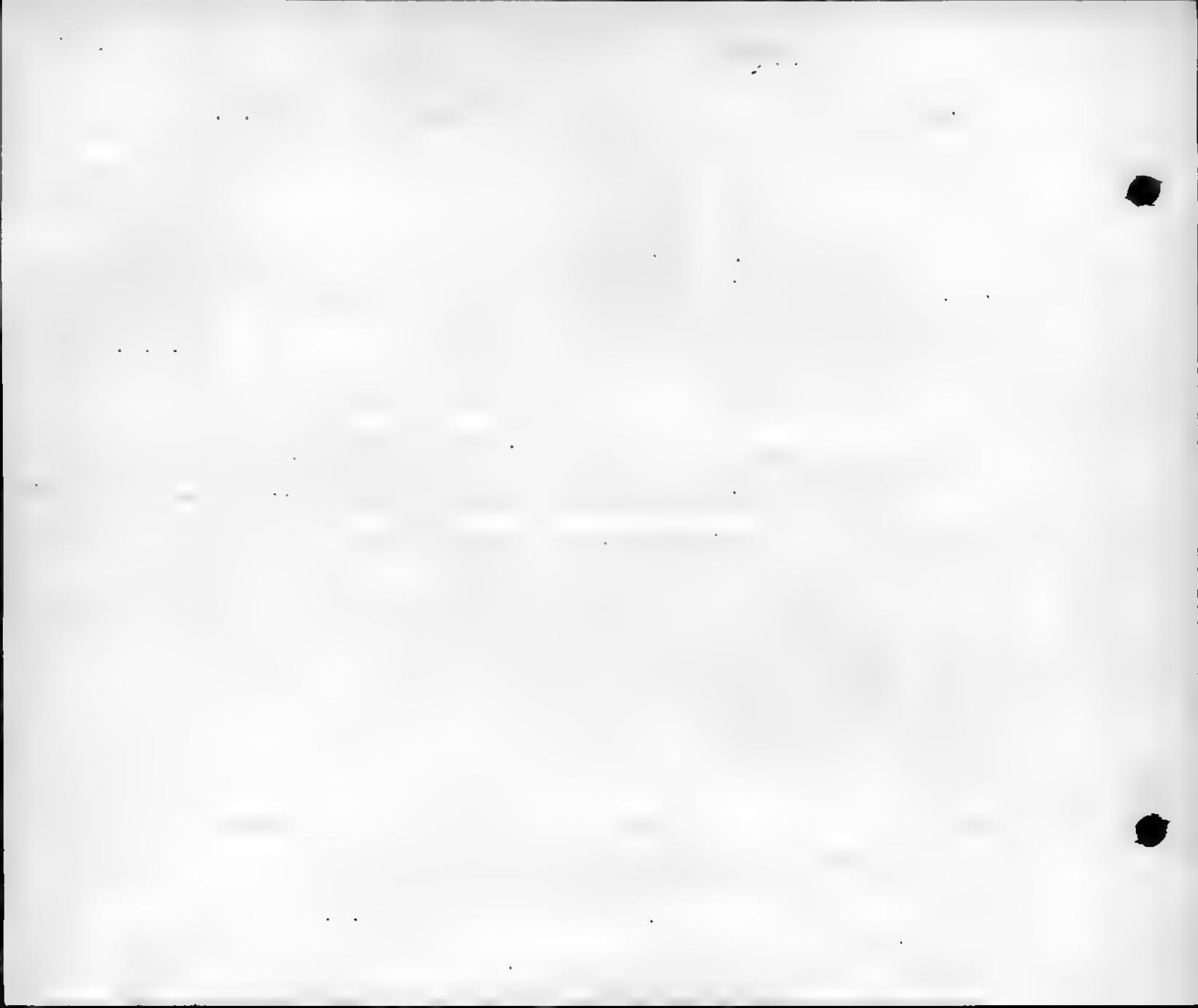
Hopping &amp; Kirkley Glen Burnie, Md.

24a. REC'D BY REGISTRAR

DATE DEC 7 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Hume



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

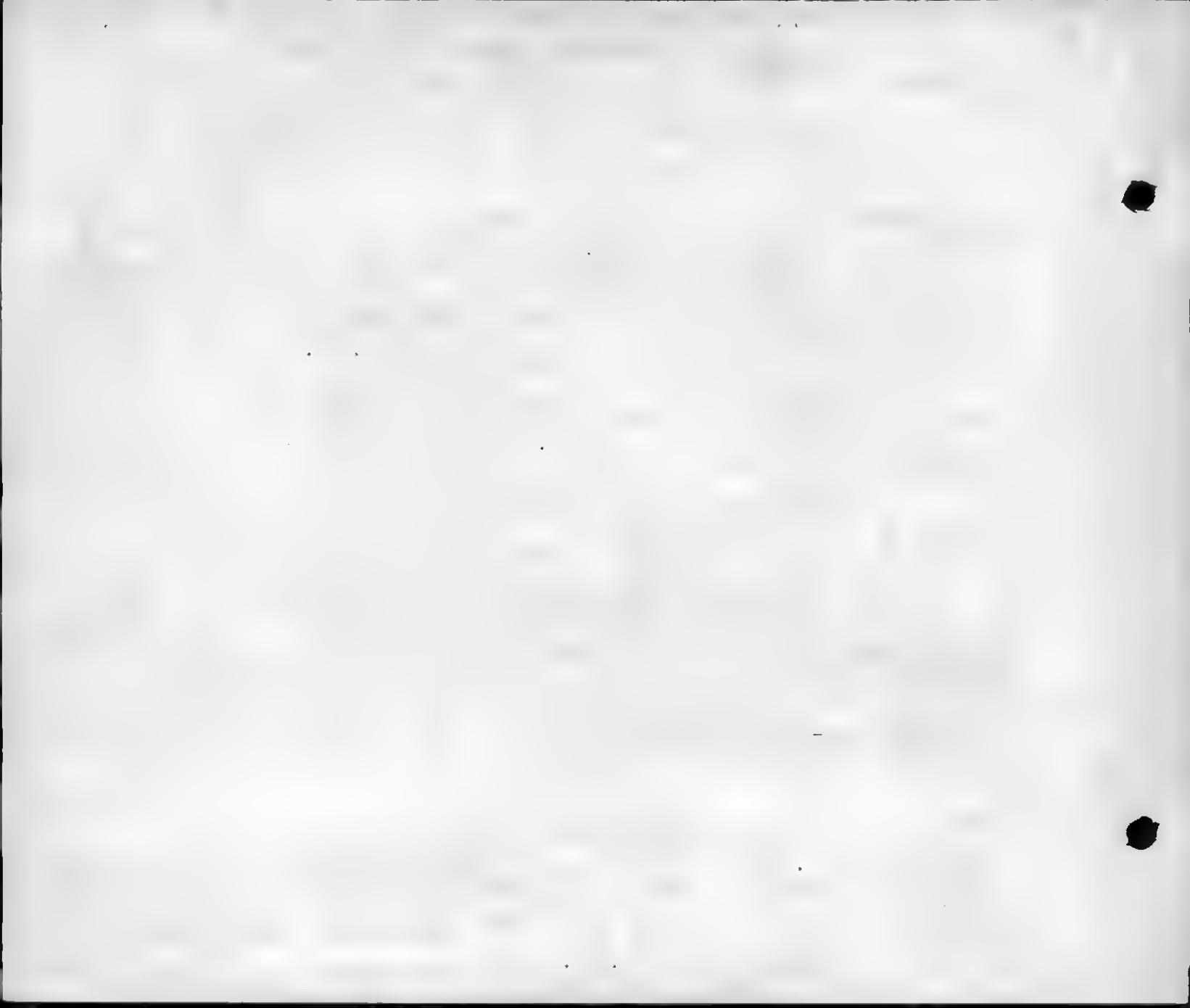
13271

13299

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Iglehart Station</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WOODROW</u> Middle <u>W</u> Last <u>LOWMAN</u>				<b>4. DATE OF DEATH</b> Month <u>DECEMBER</u> Day <u>25</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 26, 1922</u>		<b>9. AGE</b> (in years last birthday) <u>37 yrs.</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Drivers Helper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CocaCola Delivery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Crownsville, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Milton Lowman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Estell Lowman Lowman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-12-9991</u>		<b>17. INFORMANT</b> Address <u>Mr. Milton Lowman-Father- same as # 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Cardiac disease</u>  <u>434.4</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b)</span>            DUE TO <span style="float: right;">(c)</span> </div> <div style="width: 35%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH  <u>Shudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> <u>  </u> <u>  </u> <u>12-25-1959</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <u>  </u> <u>  </u> <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Elmer G. Linhardt</u>				<b>DATE SIGNED</b> <u>December 25, 1959</u>			
<b>EXAMINER'S NAME</b> (Type) <u>Elmer G. Linhardt</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>December 28, 59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Nichols Memorial</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Odenton, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home</u>				<b>ADDRESS</b> <u>Annapolis, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 29 '59</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13253

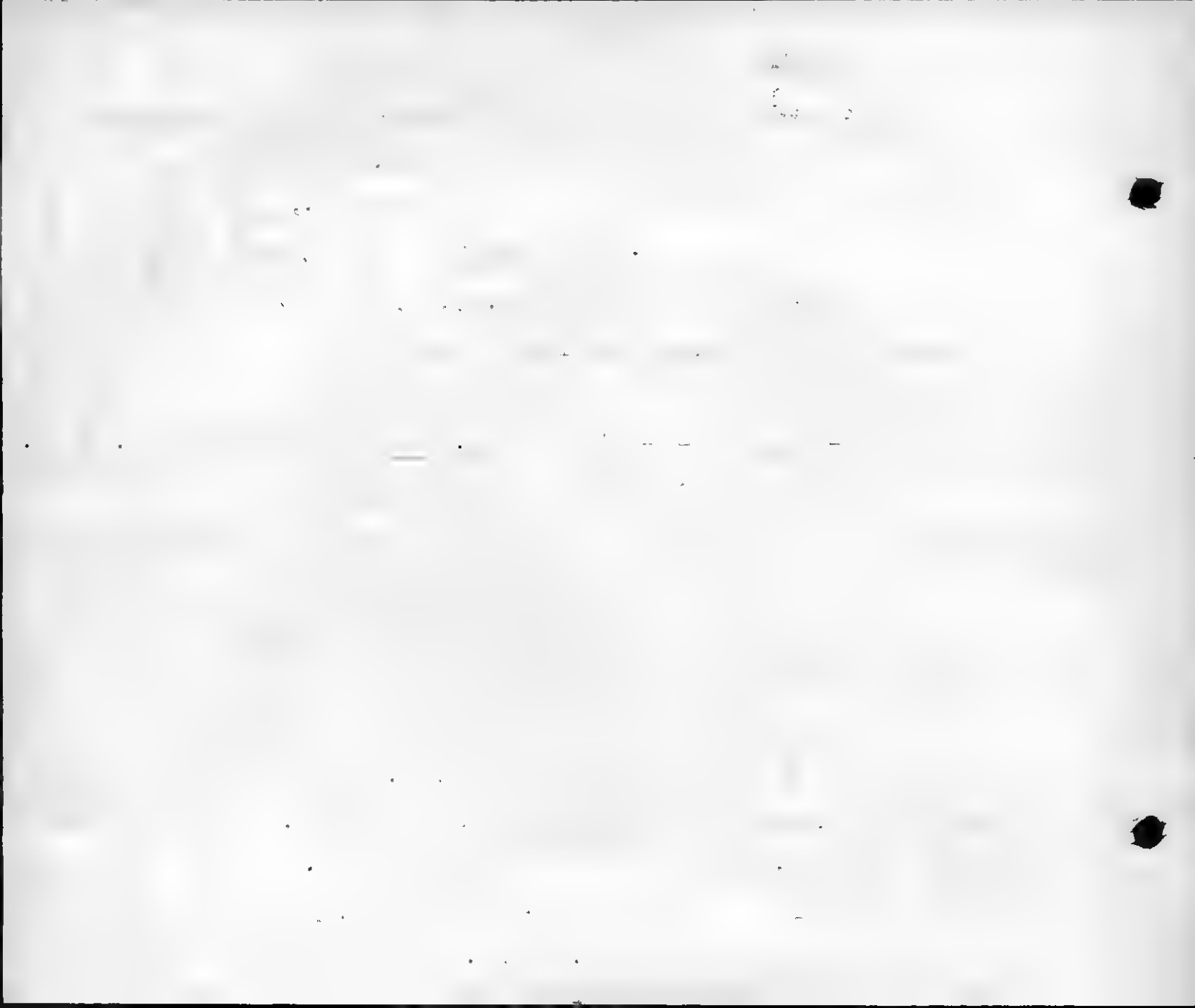
13272

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>06's Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>A.</b> Last <b>MADDOX</b>				4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>19 59</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1897</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Supplies</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gordon Maddox</b>				14. MOTHER'S MAIDEN NAME <b>Emma Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>216-05-0847</b>		INFORMANT <b>Herbert O. Smith 4407 Falls Road Balto. 11, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC ALCOHOLISM</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HIATUS HERNIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/22</b> , 19 <b>59</b> , to <b>12/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/22</b> , 19 <b>59</b> , and that death occurred at <b>5:25 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward S. Beck</b>				ADDRESS (Street, city or town, state) <b>41 Southgate Ave.,</b>		DATE SIGNED <b>12/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Edward S. BECK</b>				<b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burges Funeral Home</b>				ADDRESS <b>3831 Falls Rd. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13254

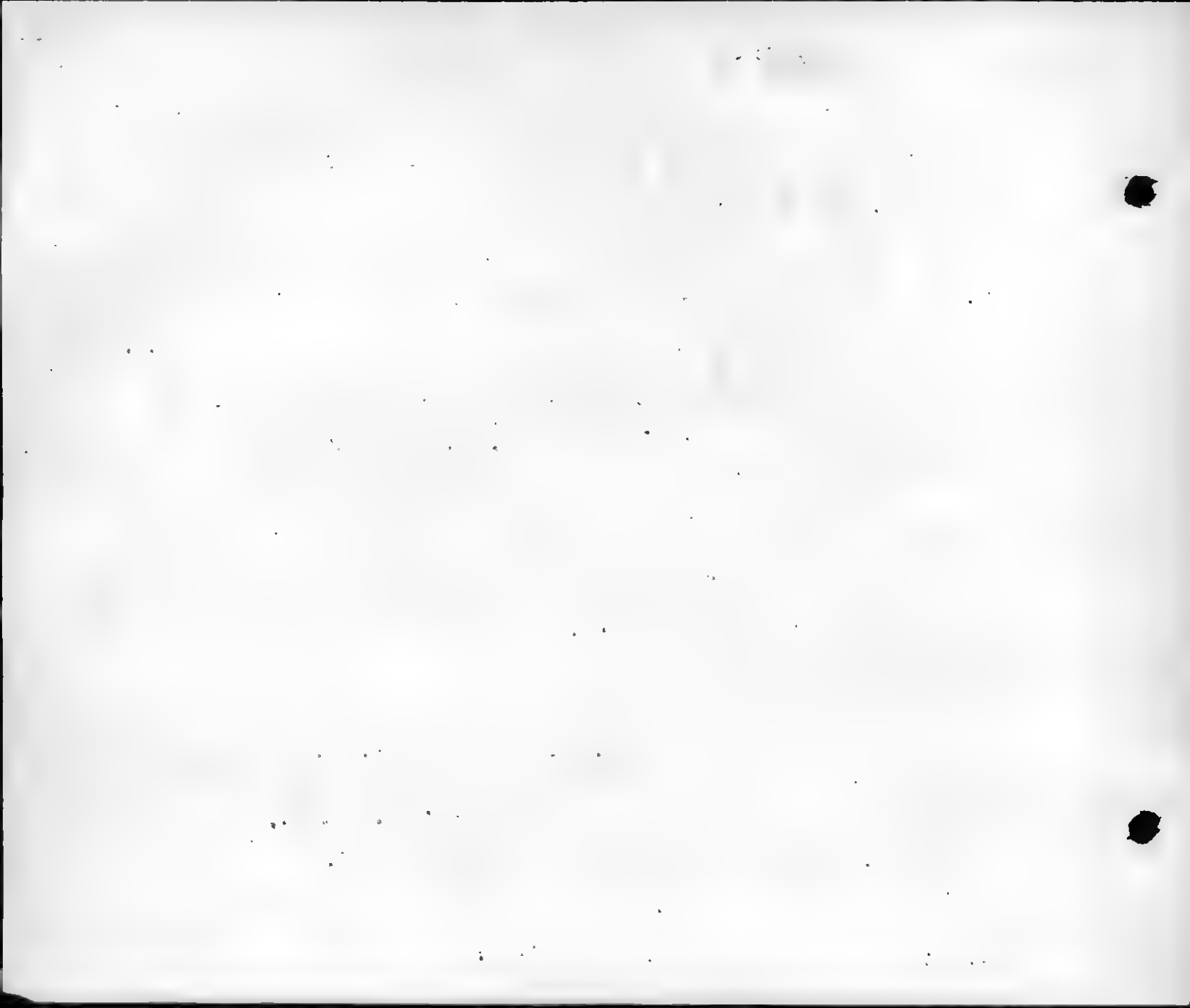
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Gambrills</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Cleveland</b> Last <b>MARQUESS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Fictum Hardesty</b>		14. MOTHER'S MAIDEN NAME <b>Frances Harrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>217-36-7352</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>coronary occlusion</b> DUE TO <b>arteriosclerotic cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>dot</b> (b) <b>dot</b> (c) <b>dot</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus, duodenal ulcer</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o m.</b> <b>19</b> p <b>m</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 24, 1959</b> , to <b>Dec. 13, 1959</b> , that I last saw the deceased alive on <b>Dec. 13, 1959</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Borssuck</b>		ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd.,</b> DATE SIGNED <b>12/14/59</b>	
PHYSICIAN'S NAME (Type) <b>S. Borssuck</b>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-59</b>	
22c. NAME OF CEMETERY OR CREMATION <b>Mt Harmony</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home (Quinn)</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	
ADDRESS <b>Quinn</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13255

Reg. Dist. No.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained in your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Wilkes County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution. Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Wilkes County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill - University</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eric</u> First <u>Lester</u> Middle <u>Medley</u> Last <u>Medley</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1954</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. FATHER'S NAME <u>John Wesley Medley</u>		10b. MOTHER'S MAIDEN NAME <u>Betty Ann Medley</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		12. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO (b) <u>...</u> DUE TO (c) <u>...</u>		14. INTERVAL BETWEEN ONSET AND DEATH <u>...</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
15a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		15b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
16a. TIME OF INJURY Hour <u>...</u> o. m. <u>...</u> p. m. <u>...</u>		16b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
17. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		18. DATE SIGNED <u>...</u>	
19. ACTUAL SIGNATURE <u>E. L. ...</u>		20. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
21. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22. DATE THEREOF <u>12-28-59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>		24. REGISTRAR'S SIGNATURE <u>...</u>	

2063 227XV4



13300

## CERTIFICATE OF DEATH

13275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Pine Haven)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Pine Haven)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel &amp; Cedar Drive</u>				d. STREET ADDRESS <u>Laurel &amp; Cedar Drive Rt. 3 Box 155</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Mitchell Jr.</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Sept. 1901</u>	9. AGE (In years last birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min <u>00</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lead work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wing Lumber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Norman Mitchell</u>			
14. MOTHER'S MAIDEN NAME <u>Eva Conerey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215 077135</u>				INFORMANT <u>Mac-Anne L. Mitchell</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 420.1 DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>November 20, 1959</u> to <u>December 8, 1959</u> , that I last saw the deceased alive on <u>Dec. 5, 1959</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Rt. 28 Box 442 Pasadena, Md.</u> DATE SIGNED <u>Dec. 8, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11 Dec 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) <u>Pasadena, Md.</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.K. Sington</u> ADDRESS <u>610 - Towne, 110</u>				24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13256

## CERTIFICATE OF DEATH

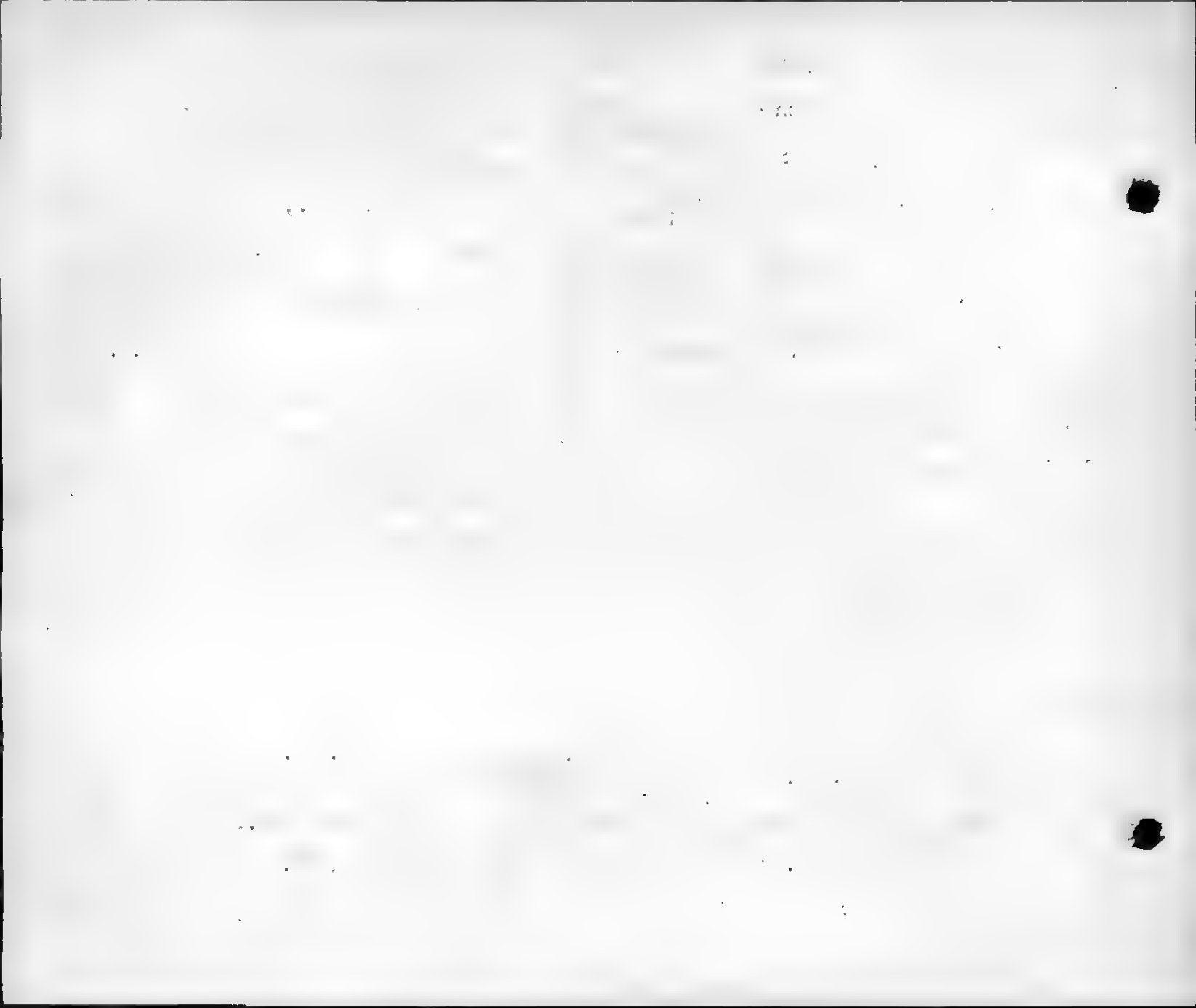
Reg. Dist. No.

13276

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>13 Thompson St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>WALKER</b> Last <b>MOORE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1902</b> <b>November 5, 1902</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MATH. INSTRUCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVAL ACA.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MILTON O. MOORE</b>				14. MOTHER'S MAIDEN NAME <b>LORENA ELWOOD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>---</b>		INFORMANT <b>ELEANOR S. MOORE #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE VASCULAR DISEASE</b> DUE TO (c) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 16, 1959</b> , to <b>Dec. 16, 1959</b> , that I last saw the deceased alive on <b>Dec. 16, 1959</b> , and that death occurred <b>12:40 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward S. Beck</b>				ADDRESS (Street, city or town, state) <b>41 Southgate Ave.,</b>		DATE SIGNED <b>12/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>				<b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12-21-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>THE WASHINGTON</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. G. Taylor</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

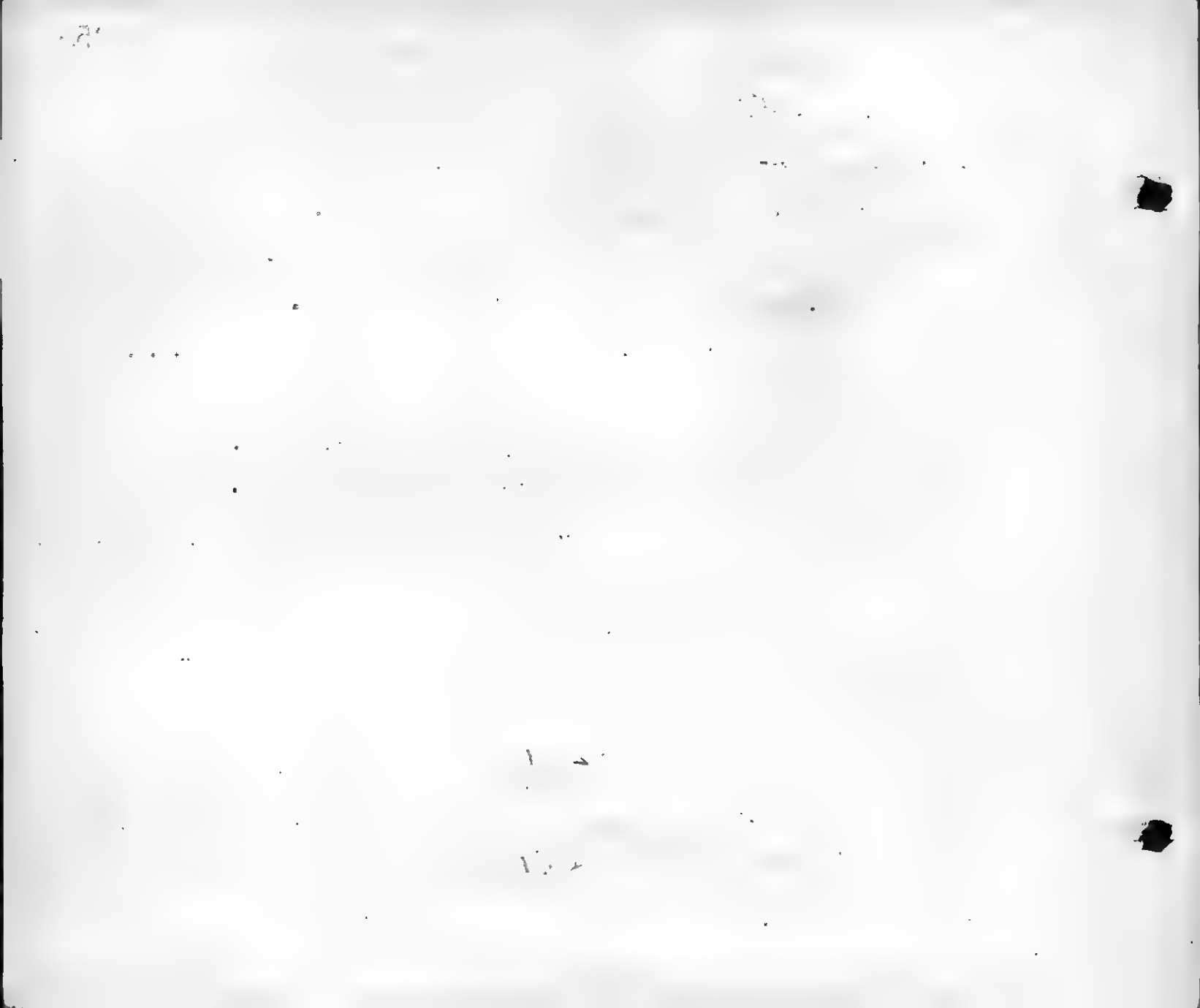
13301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Ann Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ann Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patasco Park</b>				c. LENGTH OF STAY IN 1b <b>?</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>137 Mirland Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Parker</b> Middle <b>Morton</b> Last <b>Morton</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24th.</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>In General</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unkown</b>				14. MOTHER'S MAIDEN NAME <b>Lucil Morton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>?</b>		INFORMANT <b>Mary Morton 137 Mirland Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>11/20/1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DIS.</b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DEGEN. ARTERIOS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/57</b> to <b>12/24/59</b> and that death occurred at <b>M.</b> from the causes and on the date stated above. alive on <b>12/20/19 59</b> and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>612 Belview Rd</b> DATE SIGNED <b>12/27/59</b>							
ACTUAL SIGNATURE <b>John S. Braxton Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/27th. 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cirroy O. Wilson</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

13302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Pasadena Md.</u>		c. LENGTH OF STAY IN 1b <u>6 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine B. Mulligan</u>		4. DATE OF DEATH <u>Dec. 26 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 February 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chem. Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Appleton</u>		14. MOTHER'S MAIDEN NAME <u>Bridgett Appleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-8663</u>	
17. INFORMANT <u>Mr. Charles W. Mulligan</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis; generalized.</u> DUE TO (c) <u>Hemi-plegia. left</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1959</u> to <u>December, 1959</u> that I last saw the deceased alive on <u>Dec. 22 1959</u> and that death occurred at <u>4:45 A.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis I. Codd</u>		DATE SIGNED <u>12-27-59</u>	
PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>29 Dec '59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u>		ADDRESS <u>Shen Burns, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Cecilus S. Kraus</u>	

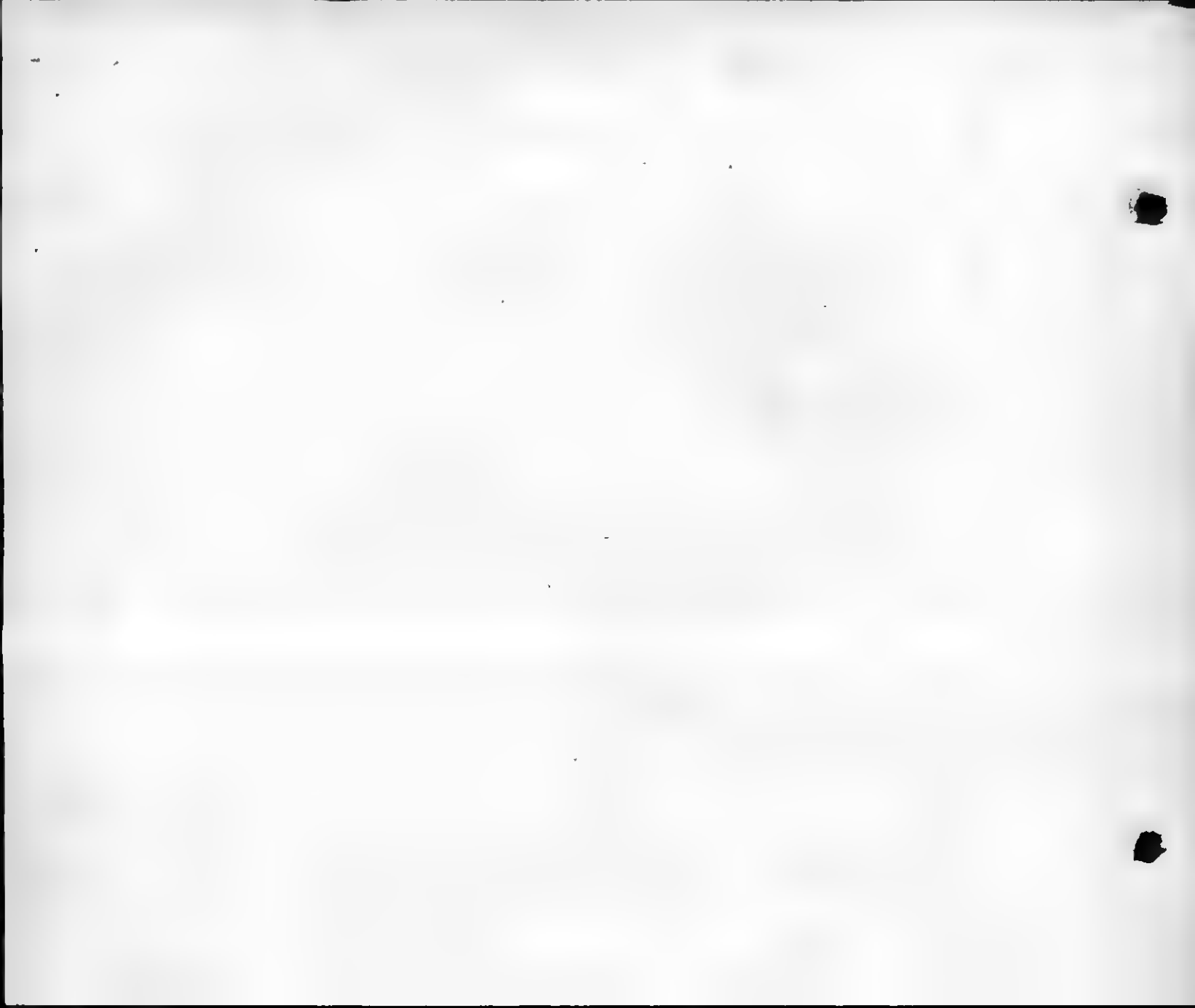
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

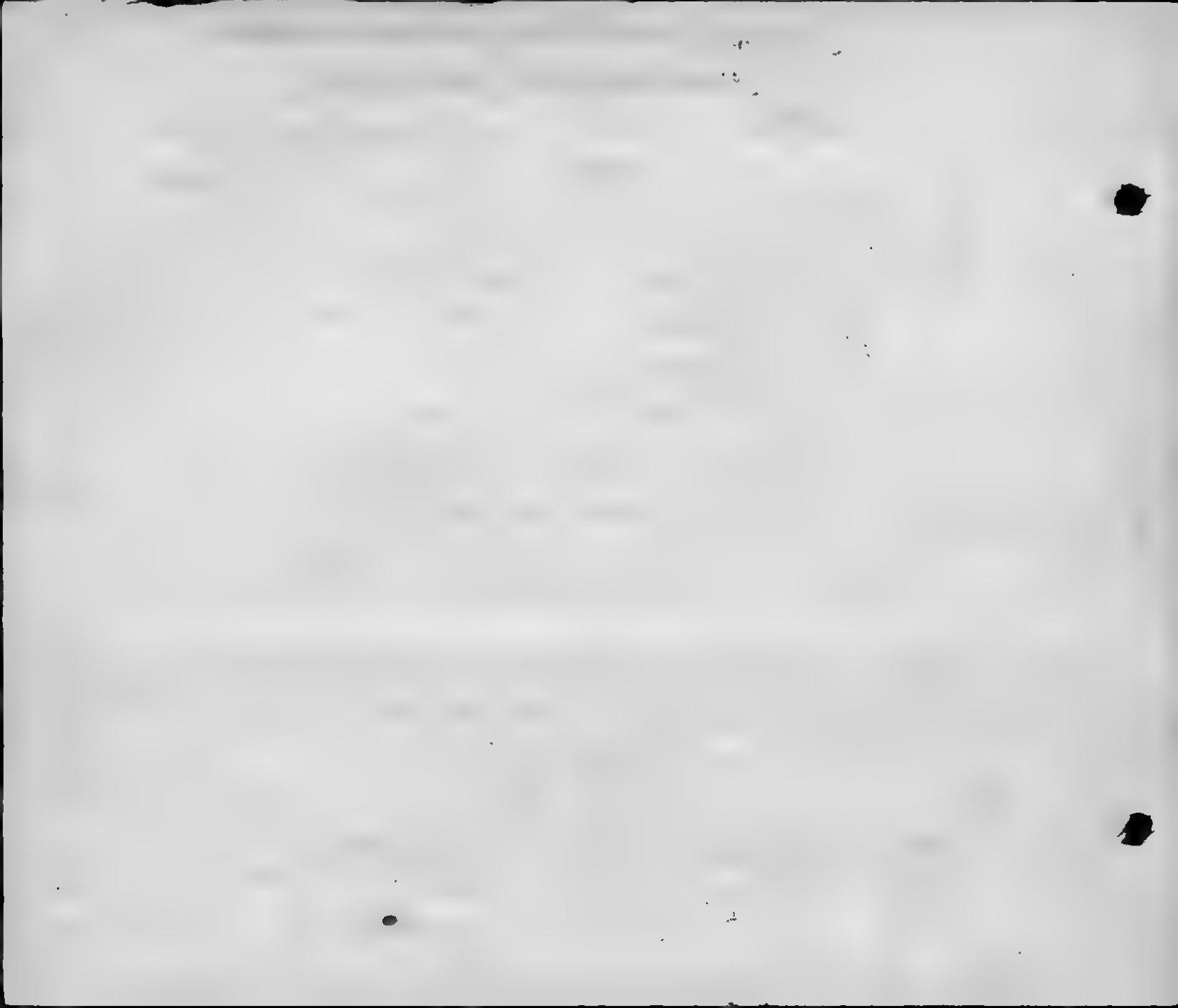
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13278

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Robert Bernard Owings</u> (First) (Middle) (Last)			4. DATE OF DEATH <u>Dec. 22</u> 19 <u>59</u> (Month) (Day) (Year)				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>3/1/81</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>			
13. FATHER'S NAME <u>WM. Wallace Owings</u>			14. MOTHER'S MAIDEN NAME <u>Mary Tydings</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Preston Owings, Shadyside Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (A) <u>Nephrosclerosis &amp; uremia</u>					<u>1 week</u>		
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes &amp;c generalized arteriosclerosis</u>					<u>years</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept</u> 19 <u>59</u> , to <u>Dec 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city, town, state) <u>Shady Side, Md.</u>		DATE SIGNED <u>12/24/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/24/59</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
24. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Burial Society, Baltimore Md.</u>				



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 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13303 CERTIFICATE OF DEATH

13273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>Furnace Branch Rd., Glen Burnie</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Paul</b> Last <b>Paul</b>		4. DATE OF DEATH Month <b>12</b> - Day <b>26</b> - Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-1874 (1896)</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>
13. FATHER'S NAME <b>Andy Paul</b>		14. MOTHER'S MAIDEN NAME <b>Phyllis Paul</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service))		16. SOCIAL SECURITY NO.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Senile mental changes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1957</b> , 19 <b>59</b> , to <b>December 26, 1959</b> , that I last saw the deceased alive on <b>December 19, 1959</b> and that death occurred at <b>7:27 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Pair</b>		ADDRESS (Street city or town, state) <b>400 N. Carrollton Avenue</b>	
PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		DATE SIGNED <b>12-28-1959</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		22d. LOCATION (City town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson Funeral Home Inc.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS <b>916 Penna. Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline S. Haines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13280

13304

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel,</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN b <b>10 weeks</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Baltimore, Md.</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				d. STREET ADDRESS <b>830 N. Washington Street.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANDREW PAYTON</b>		First		Middle		Last		4. DATE OF DEATH Month <b>December</b> , Day <b>6</b> , Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 6, 1893</b>		9. AGE (In years last birthday) <b>66 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel mill</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Cole Payton</b>				14. MOTHER'S MAIDEN NAME <b>Harriett McEmery</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-8653</b>		17. INFORMANT <b>Bertie Hart</b> Address <b>4855 High St. Cambridge Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b> <b>4 months</b> <b>15 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe dementia due to cerebral anoxia.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 23, 1959</b> , to <b>Dec. 6, 1959</b> , that I last saw the deceased alive on <b>December 5, 1959</b> , and that death occurred at <b>3:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>400 N. Carrollton Ave. Baltimore 23, Maryland</b> DATE SIGNED <b>12-7-1959</b>									
ACTUAL SIGNATURE <b>James M. Pair</b>				M.D. <b>James M. Pair, M.D.</b>					
PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>O.A. County, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph B. Locks Jr.</b>				ADDRESS <b>1304 N. Central Ave.</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13305

## CERTIFICATE OF DEATH

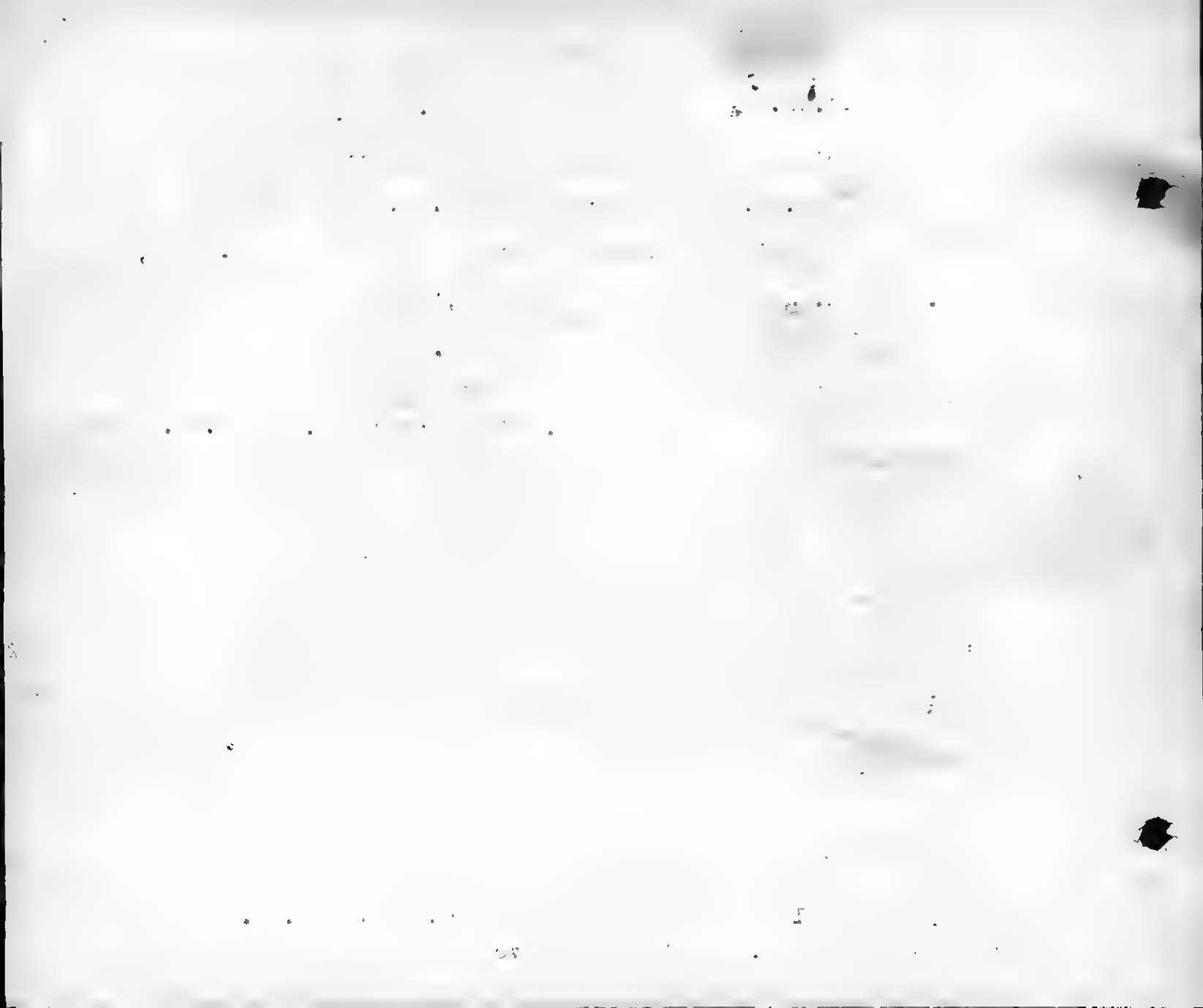
## 13281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A.A.Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1820 N.St.Augustine Ave</b>		d. STREET ADDRESS <b>1820 N.St.Augustine Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Irene</b> Last <b>Peters</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8,</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Collins Bensal</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senile Hypertension</b> (c) <b>Chronic Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b> <b>2 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 7</b> 19 <b>59</b> , to <b>Dec 8</b> 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 7</b> 19 <b>59</b> , and that death occurred at <b>5:30</b> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L.A. Lally</b>		DATE SIGNED <b>3517 Edmondson Ave</b>	
PHYSICIAN'S NAME (Type) <b>L.A. LALLY M.D.</b>		ADDRESS (Street, city or town, state) <b>Baltimore 29 Ind Synd 12/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Contry</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>John S. Kline</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13258

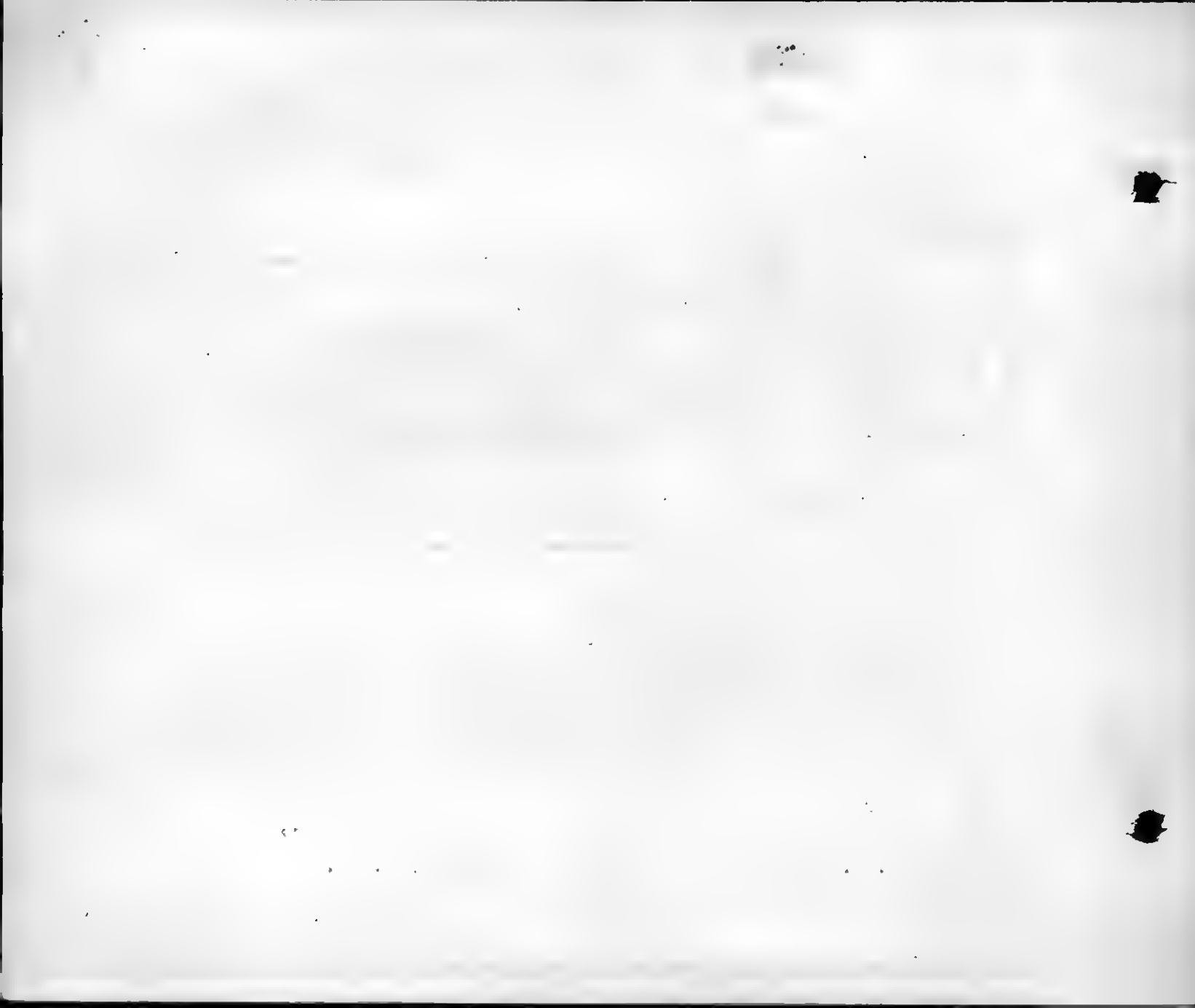
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>Henry</u> Middle <u>Poole</u> Last <u>Poole</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>19</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>		INFORMANT <u>Rufus Poole Miller</u> Address <u>1112</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>advanced senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7x hip left; arteriosclerosis</u> DUE TO (c) <u>7. old</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>7. old</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> <u>29</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-29</u> , 19 <u>59</u> , to <u>12-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-18</u> , 19 <u>59</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Landmesser</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u>		DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Landmesser</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>12-23-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garden Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Waterbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Rose</u>		ADDRESS <u>#1007, 1008 &amp; 1009 St. Annapolis, Md.</u>		24a. RECEIVED BY REGISTRAR <u>DEC 22 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13283

13306

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. LENGTH OF STAY IN 1b <b>5 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Edna Road, Rockview Beach</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Pumphrey</b> Last <b>Pumphrey</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1880</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months <b>79</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Braumbardt</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Towbar</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>216-07-5411-A</b>	
INFORMANT <b>Bertha Ricker</b>		Address <b>Same as 2c above</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerosis Cardiovascular disease</b> <b>260 x</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 years</b> <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 7, 1958</b> to <b>December 15, 1959</b> , that I last saw the deceased alive on <b>December 15, 1959</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.M. McLaughlin</b>		ADDRESS (Street, city or town, state) <b>R.F.D. 8 Box 442 Pasadena Md.</b>	
PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin, M.D.</b>		DATE SIGNED <b>Dec 15, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 25, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>		24a. REC'D BY REGISTRAR <b>DEC 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13307**  
**CERTIFICATE OF DEATH**

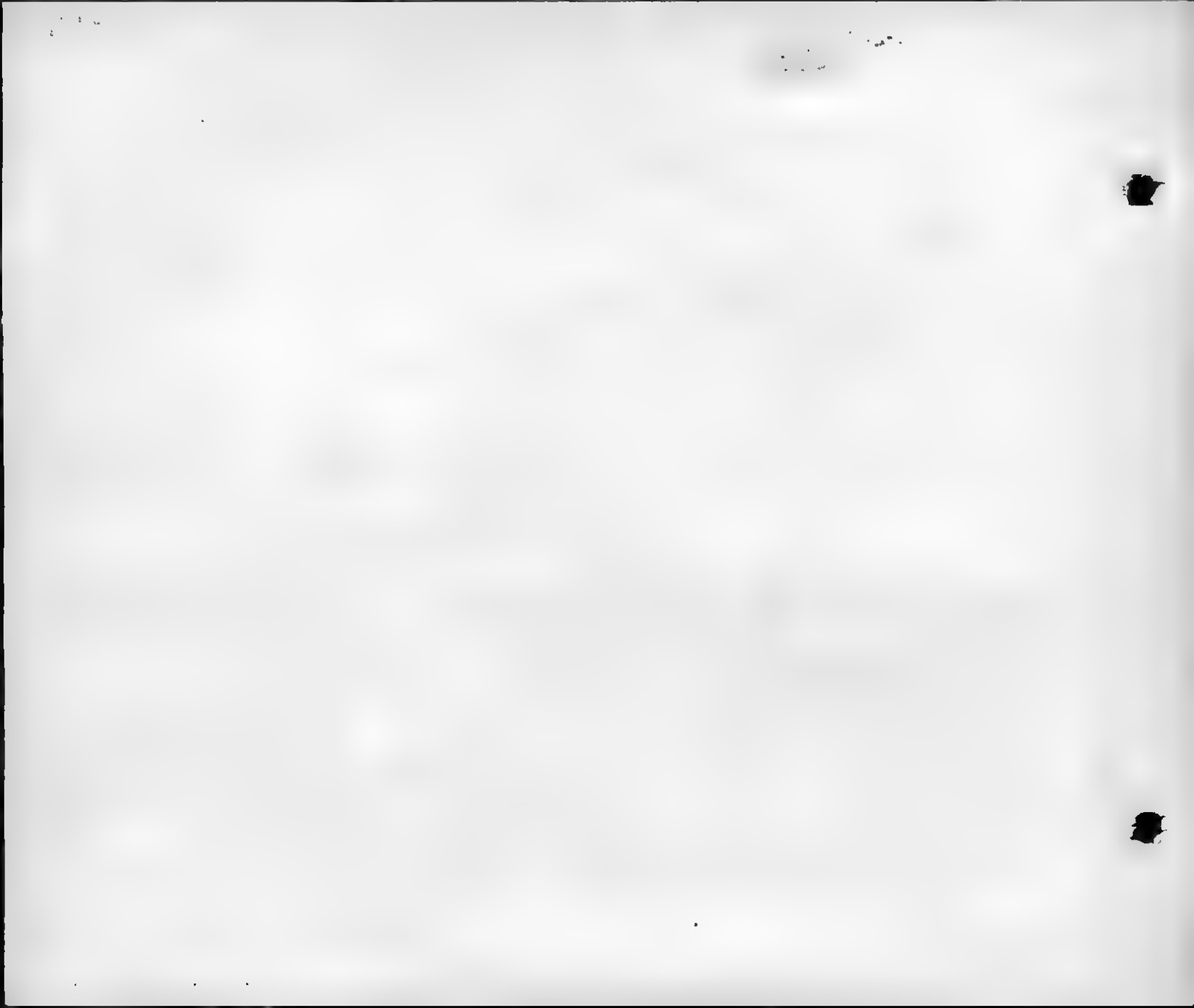
13284

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>		c. LENGTH OF STAY IN 1b <u>670</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAMBRILLS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAVIDSONVILLE RD.</u>				d. STREET ADDRESS <u>DAVIDSONVILLE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DWAYNE A. PURDHAM</u>				4. DATE OF DEATH Month Day Year <u>DEC. 13 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 11, 1954</u>	
9. AGE (In years last birthday) yrs <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MARYLAND</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY PURDHAM</u>				14. MOTHER'S MAIDEN NAME <u>EVA MOREHAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. HARRY PURDHAM - FATHER - #2</u>			
				Address <u>SAME AS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE -</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGENITAL HEART DISEASE -</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 16, 1959</u> , to <u>Dec. 13, 1959</u> , that I last saw the deceased alive on <u>Nov. 16, 1959</u> , and that death occurred at <u>10 pm</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Felix Fremling</u> M.D.				ADDRESS (Street, city or town, state) <u>609 Odenton Rd</u>			
PHYSICIAN'S NAME (Type) <u>Felix Fremling</u>				DATE SIGNED <u>12/14/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN HAVEN CEMET.</u>		22d. LOCATION (City, town, or county) (State) <u>GREEN BELT, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOBSON FUNERAL HOME</u>				ADDRESS <u>ANNAPOLIS MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

206344 7XV5





# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 10, 13, 14, 15 Filing 254 1-8-60 et

13285

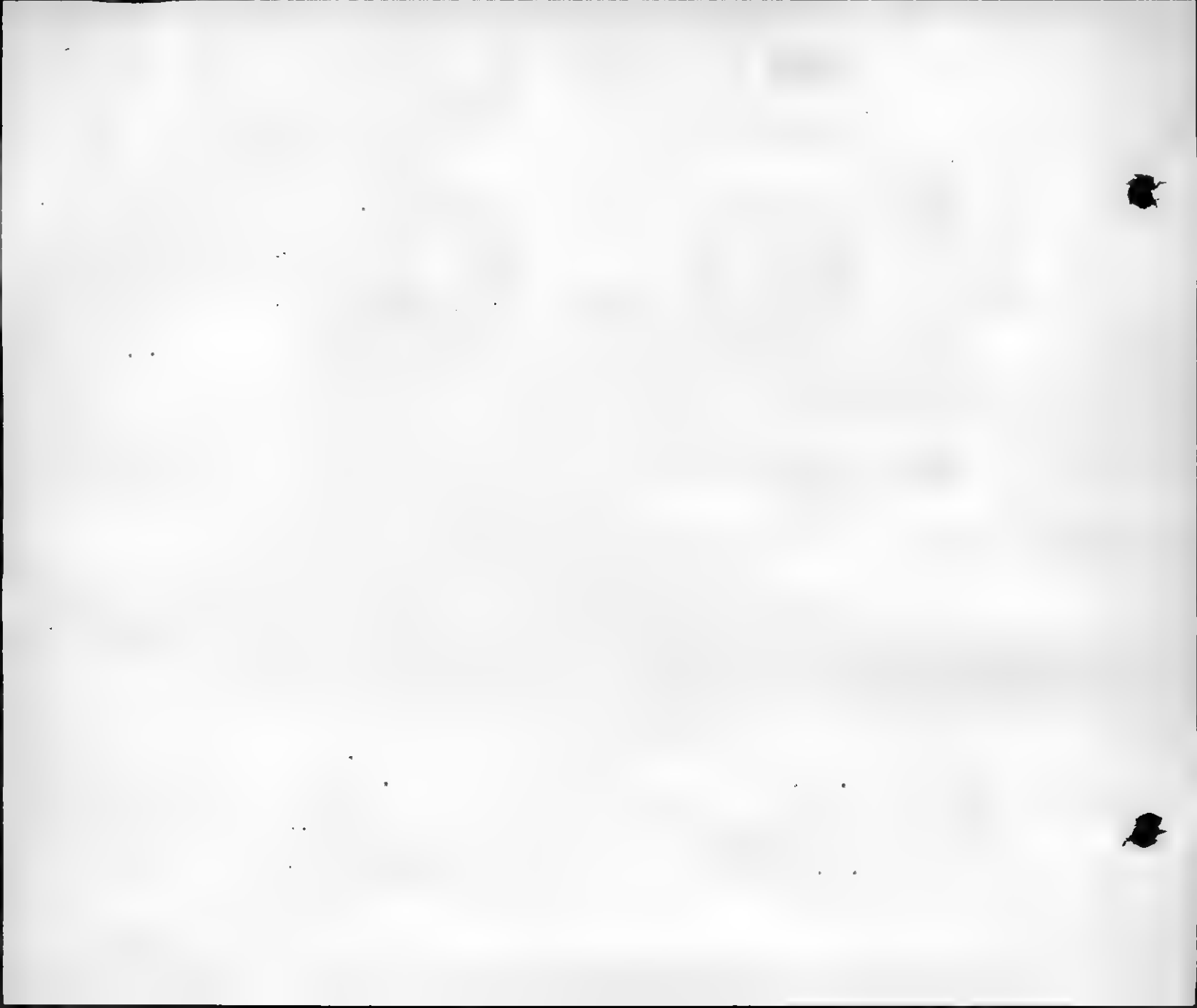
13259

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>74 East St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>QUEEN</b> Last <b>QUEEN</b>				4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1901</b>		9. AGE (In years lost birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	IF UNDER 24 HRS Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Queen, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>445X</b> DUE TO <b>Cochon Longstone Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) <b>Pulmonary Edema</b>			
				(c) <b>Hypertensive Cardia Vascular Disease IV</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 1959, to <b>Dec. 29,</b> 1959, that I last saw the deceased alive on <b>Dec. 29,</b> 1959, and that death occurred at <b>2:25AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Heedee H. Johnson</b> M.D.				ADDRESS (Street, city or town, state) <b>37 Calvert St.,</b>		DATE SIGNED <b>12/30/59</b>	
PHYSICIAN'S NAME (Type) <b>T. H. Johnson</b>				<b>Annapolis, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>		22b. DATE THEREOF <b>Jan 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brown's</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold A. ...</b>				ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

TO HOSPITAL 24. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13303

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dells Grove.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dells Grove - Anne Arundel Co.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>J.</u> Last <u>ROCKEL</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 11, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B+O. RR. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>ROBERT ROCKEL</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN TANTZ.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>CAROLINE B. ROCKEL</u> Address <u>SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Jeller</u> ADDRESS <u>4015 CONNELL ST. BALTO. 24, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1552

13310

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V21 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>347 Camp Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Will Shufford</u> Middle <u>(Shoe Foot)</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>24th</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/68</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Shufford</u>				14. MOTHER'S MAIDEN NAME <u>Susan White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Plaza Manor Nursing Home Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c) <u>General Arteriosclerosis</u> DUE TO (c) <u>General Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Home</u>	<u>12-30-59</u>	<u>Cornelia Am</u>		<u>Cornelia Am</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O W Isaac</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. King</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1113. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





13311

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green Spring</i>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <i>St. Elizabeth's Hospital</i>		d. STREET ADDRESS <i>Box 364</i>	
3. NAME OF DECEASED (Type or print) <i>Agustine</i> First <i>Shorter</i> Last		4. DATE OF DEATH <i>December 27</i> 19 <i>59</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>E</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 25-1900</i> 39 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lawyer</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C., Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>217-16-6284</i>	
17. INFORMANT <i>Emma Shorter</i>		Address <i>Adenton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Sclerotic Cardio Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Left Hemiplegia</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>59</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>Adenton</i> (County) <i>Prince George's</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>12-17-59</i> , 19 <i>59</i> , to <i>12-27-59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-27-59</i> , and that death occurred at <i>4:30</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John J. Freeman</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 37 Adenton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>John J. Freeman</i>		DATE SIGNED <i>12-27-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>12-31-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mission Baptist</i>	22d. LOCATION (City, town, or county) <i>Adenton, Md.</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Keenath</i>		ADDRESS <i>Adenton, Md.</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	
DATE <i>DEC 30 '59</i>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13260

CERTIFICATE OF DEATH

13289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert E. Simmons</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1878</b>
9. AGE (In years last birthday) <b>81</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ins. City Employee</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Anne Arundel</b>	
13. FATHER'S NAME <b>ROBERT H SIMMONS</b>		14. MOTHER'S MAIDEN NAME <b>SARAH E STALLINGS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>WAYNARD L SIMMONS</b> Address <b>384 Gibson Rd Annapolis Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (c) <b>5 YEARS</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE</b> , 1955, to <b>12 DEC</b> , 1959, that I last saw the deceased alive on <b>11 DEC</b> , 1959, and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Southgate Ave Annapolis Md</b> DATE SIGNED <b>12/14/59</b> ACTUAL SIGNATURE <b>Edward H. Bede</b> PHYSICIAN'S NAME (Type) <b>Annapolis Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Belcrest Cent</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		24a. REC'D BY REGISTRAR <b>DEC 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>



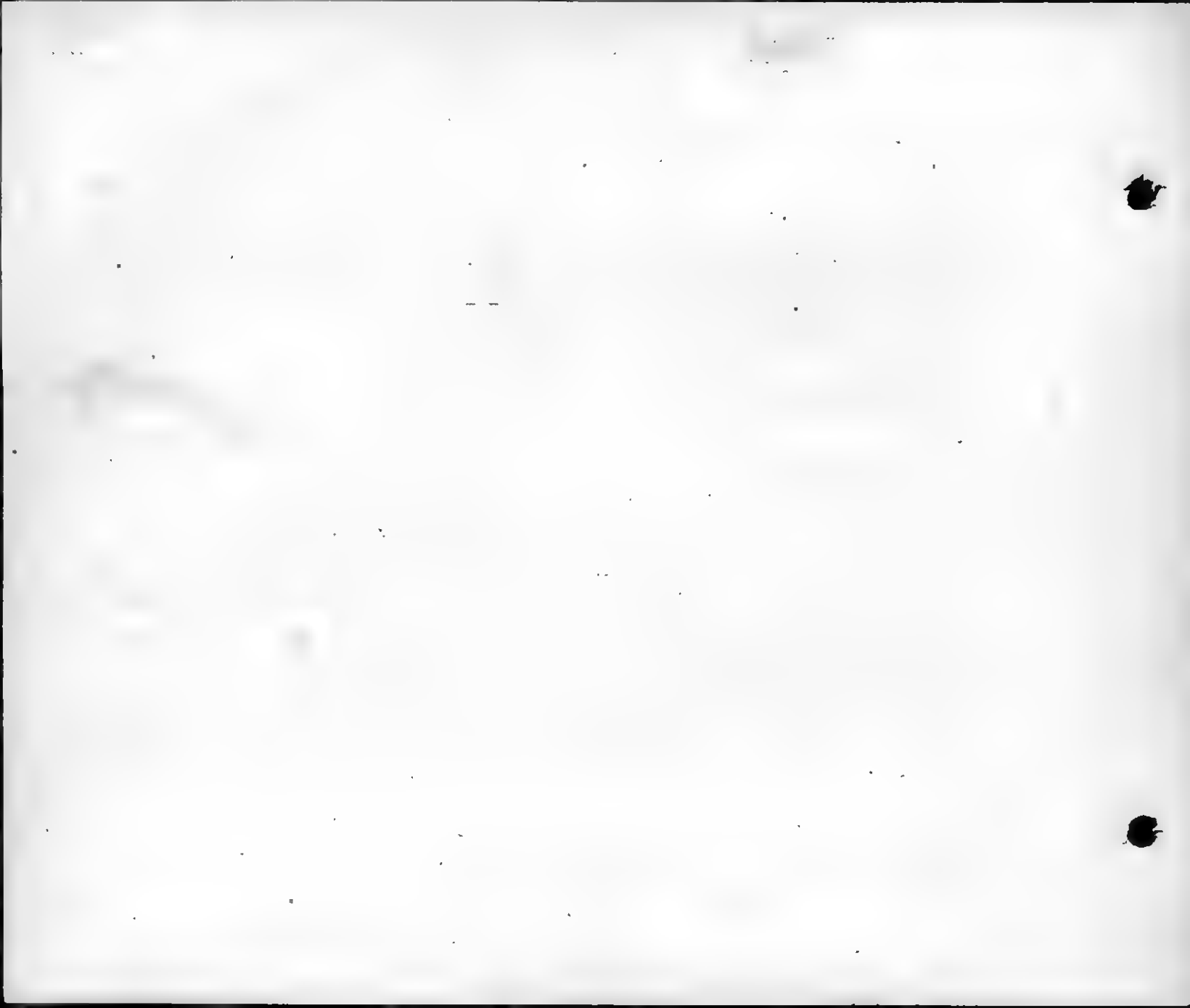
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13312** Item 8 Film G253 12-11-59 et  
**CERTIFICATE OF DEATH**

13290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Ann A. Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freetown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freetown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Freetown Road Rt. #1 Box 339A</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harriett</b> Middle <b>Spruill</b> Last <b>Spruill</b>				4. DATE OF DEATH Month <b>December</b> Day <b>3rd</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb-2-1906</b> 1907	9. AGE (In years last birthday) <b>52</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Smith</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		INFORMANT Address <b>Frank Spruill Route 1, Box 339A Glenburnie Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-Vascular Disease</b> DUE TO <b>Hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>2 yr -</b> <b>10 yr -</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 2</b> , 19 <b>59</b> , to <b>Dec 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec-3</b> , 19 <b>59</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas L. Ball Jr</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>303 W. Maple Rd. 13/6/59</b>			
PHYSICIAN'S NAME (Type) <b>Linthicum Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas O. Wilson</b>				ADDRESS <b>1100 Bunting</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## Reg. Dist. No.

13291

**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55





13261

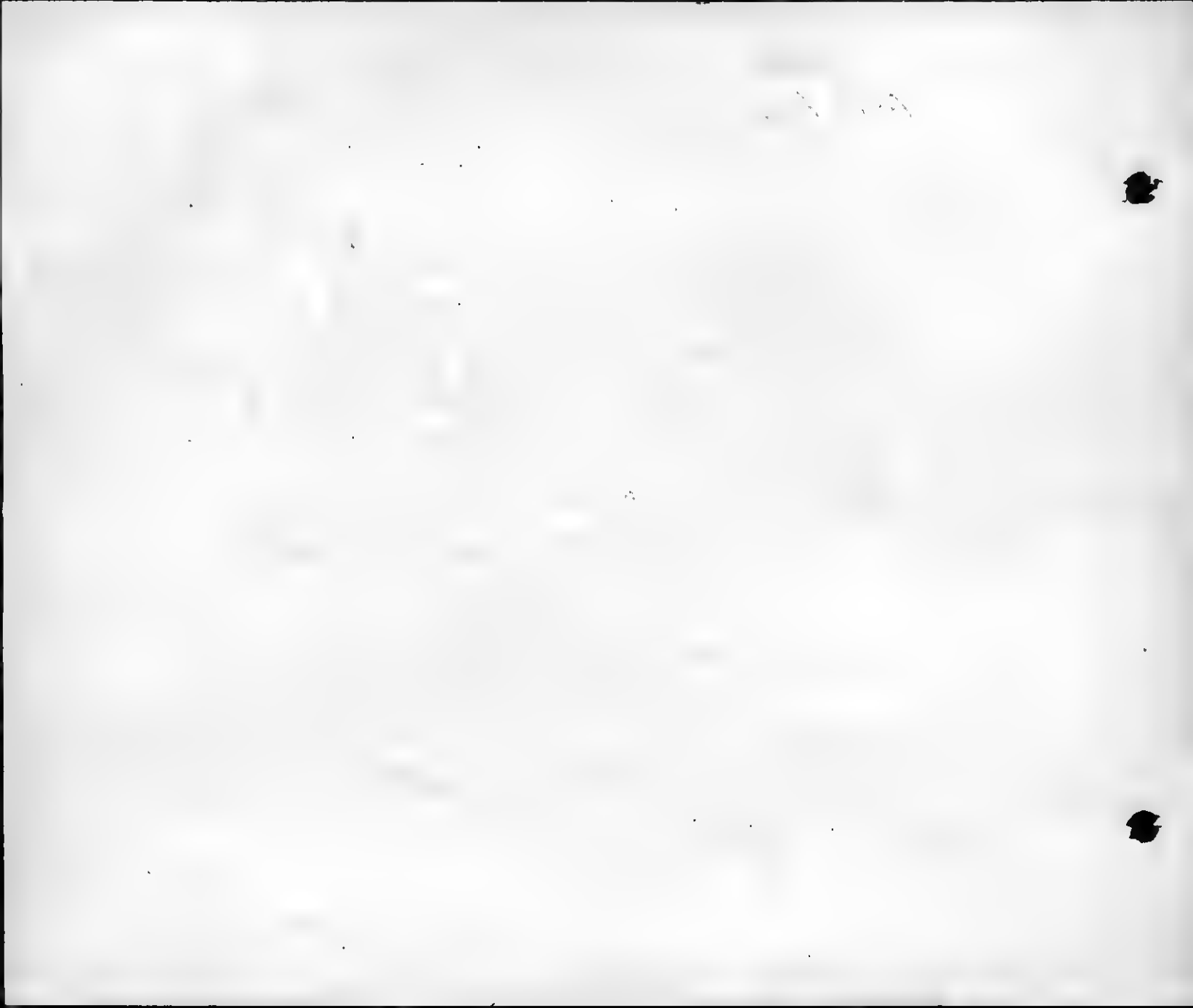
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT 4, Box 392, Annapolis, Md.</b>		d. STREET ADDRESS <b>RT 4, Box 392, Old Annapolis Blvd</b>	
3. NAME OF DECEASED (Type or print) First <b>Adolf</b> Middle <b>Mieczyslaw</b> Last <b>Stejowski</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>m.</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Mills</b>	
11. BIRTHPLACE (State or foreign country) <b>Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>(German ✓ West Germany)</b>	
13. FATHER'S NAME <b>Jan G. Stejowski</b>		14. MOTHER'S MAIDEN NAME <b>Ortylia Cihman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Elizabeth A Winiarz, daughter, same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalis</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1959</b> to <b>12-12-1959</b> that I last saw the deceased alive on <b>12-3-1959</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>65 HAW ST. ANNAPOLIS, MD.</b> DATE SIGNED <b>12/12/59</b>			
ACTUAL SIGNATURE <b>James R. Martin</b> M.D.		PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kathleen A. Hight-Cyganick, Inc.</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 31 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. L. H. H.</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

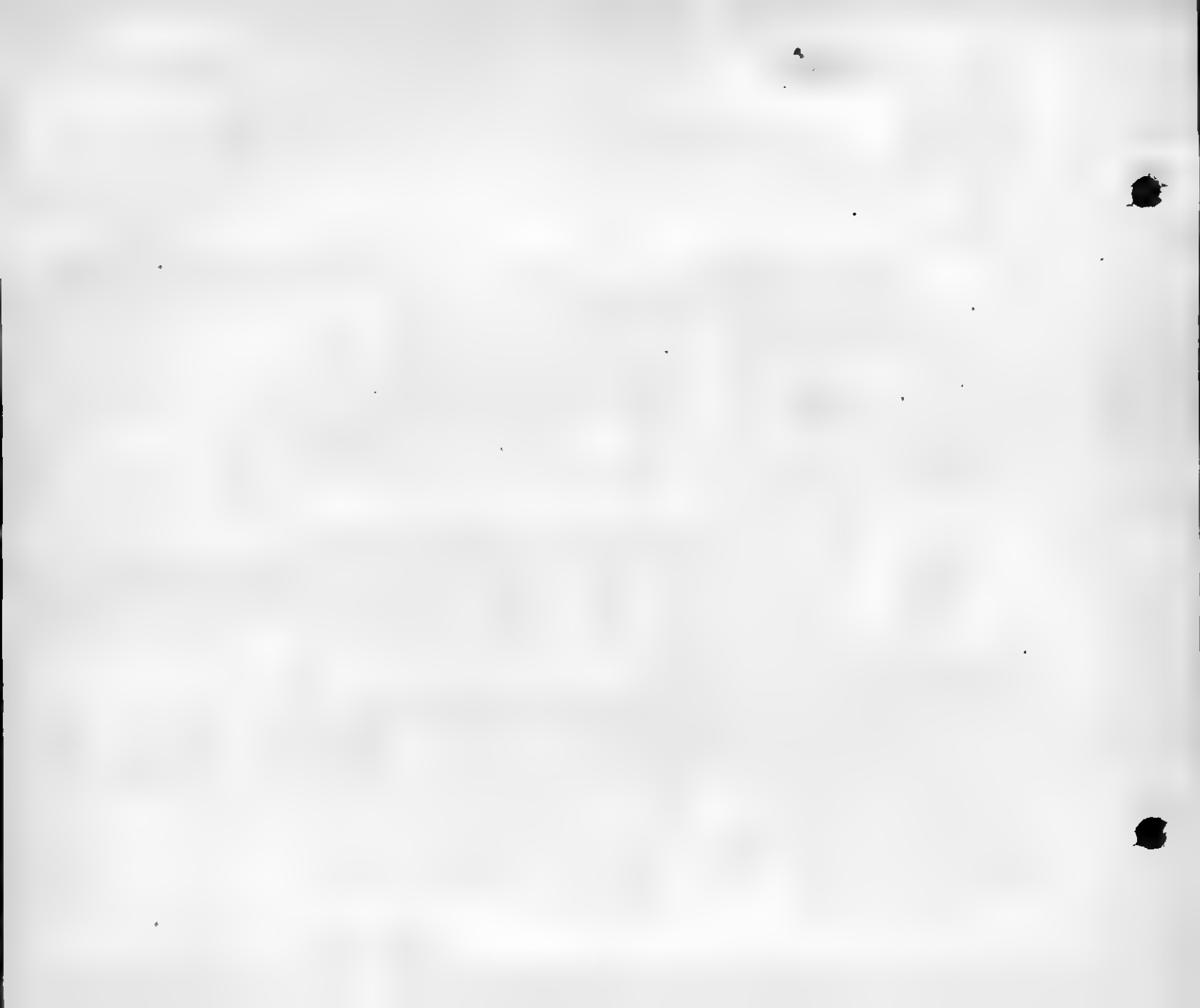
Reg. Dist. No.

13293

13314

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>123 Cecil Rd. Rivera Beach</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>William George Stevens</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>December 18th.</u> 19 <u>59</u> Month Day Year					
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/6/97</u>		<b>9. AGE</b> (In years last birthday) <u>62 yrs.</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>General Foreman for B.&amp;O.R.R..</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William H. Stevens</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Sadler</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs. Thelma M. Stevens (Wife)</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4' 11"</u> DUE TO (b) <u>Hypertensive Cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>?</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>12/18/59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/21/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Mr. Cully Z. Home, 130 E. Zellerbach, Baltimore, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 21 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13315

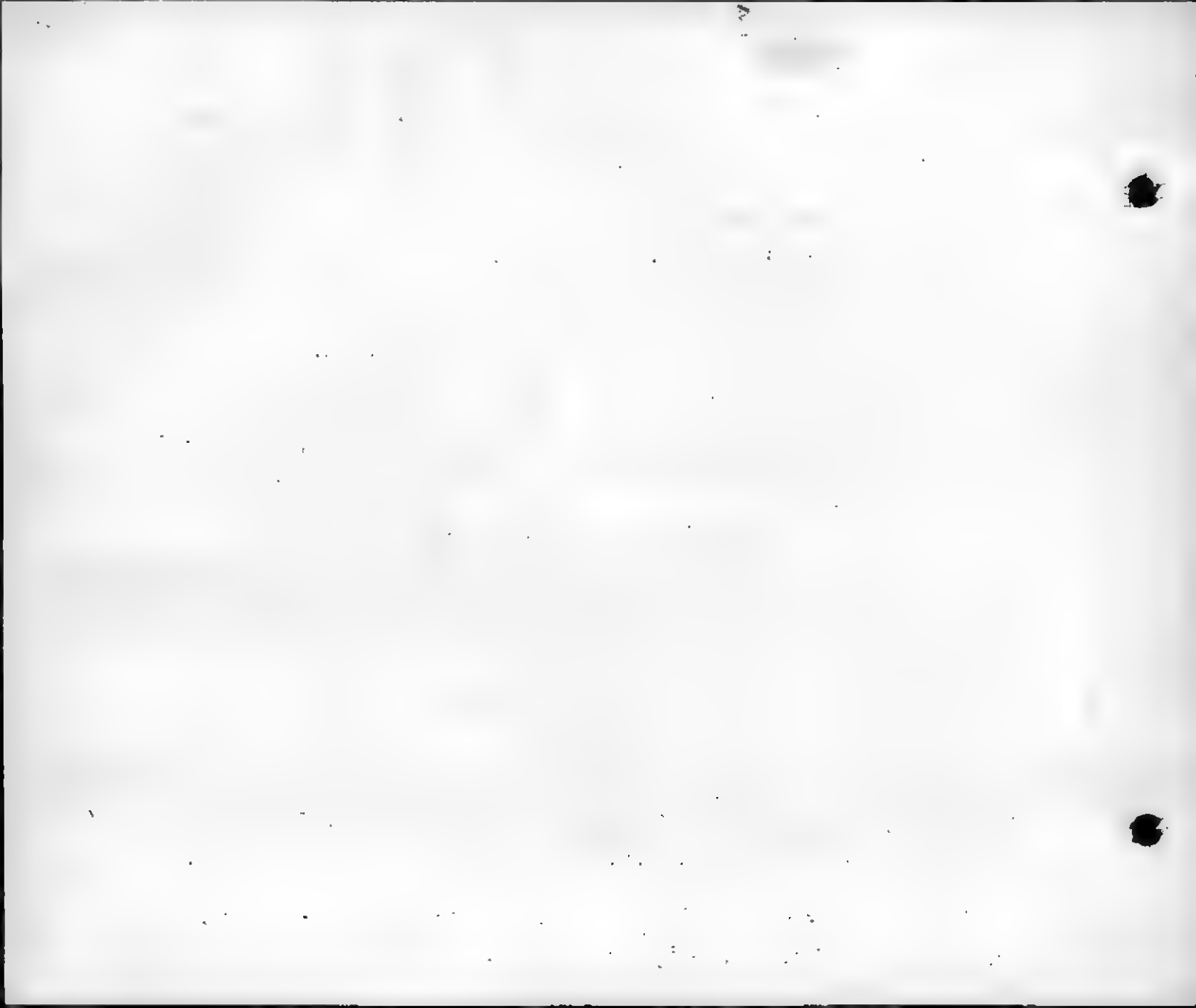
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rezin S. Stinchcomb</b>		4. DATE OF DEATH Month Day Year <b>12/20/ 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/1870</b>
9. AGE (In years last birthday) yrs <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Severn, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua Stinchcomb</b>		14. MOTHER'S MAIDEN NAME <b>Louise Ann Boyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Morris Stinchcomb, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-vascular Renal Disease</b> <b>442X</b> DUE TO (b) <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4-5 yrs</b> <b>10-15 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>12/20/59</b> , 19____, that I last saw the deceased alive on <b>12/20/59</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 W. Maple Rd. Linthicum, Md.</b> DATE SIGNED <b>12/21/59</b>			
ACTUAL SIGNATURE <b>Charles d. Ball, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles Ball, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Harmons Burying Ground</b>		22d. LOCATION (City, town, or county) (State) <b>Severn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 23 '59</b>	
ADDRESS <b>Glen Burnie, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13295

13262

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>H.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WEST ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>H.</u> Last <u>STRANGE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WOMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WOMAN</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ROBERT E. STRANGE</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE YEWELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>L. EARL STRANGE</u> Address <u>316 WASHINGTON ST. ANNAPOLIS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u>							<u>3 DAYS</u>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>CARCINOMA OF BREAST METASTATIC</u>							<u>3 YRS.</u>
DUE TO							
(c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 1958, to <u>11 DEC.</u> , 1959, that I last saw the deceased alive on <u>10 DEC.</u> , 1959, and that death occurred at <u>11:59 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis Md</u>			
DATE SIGNED <u>12/11/59</u>							
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis, Md.</u>		24a. RECEIVED BY REGISTRAR <u>DEC 14 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Robert S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



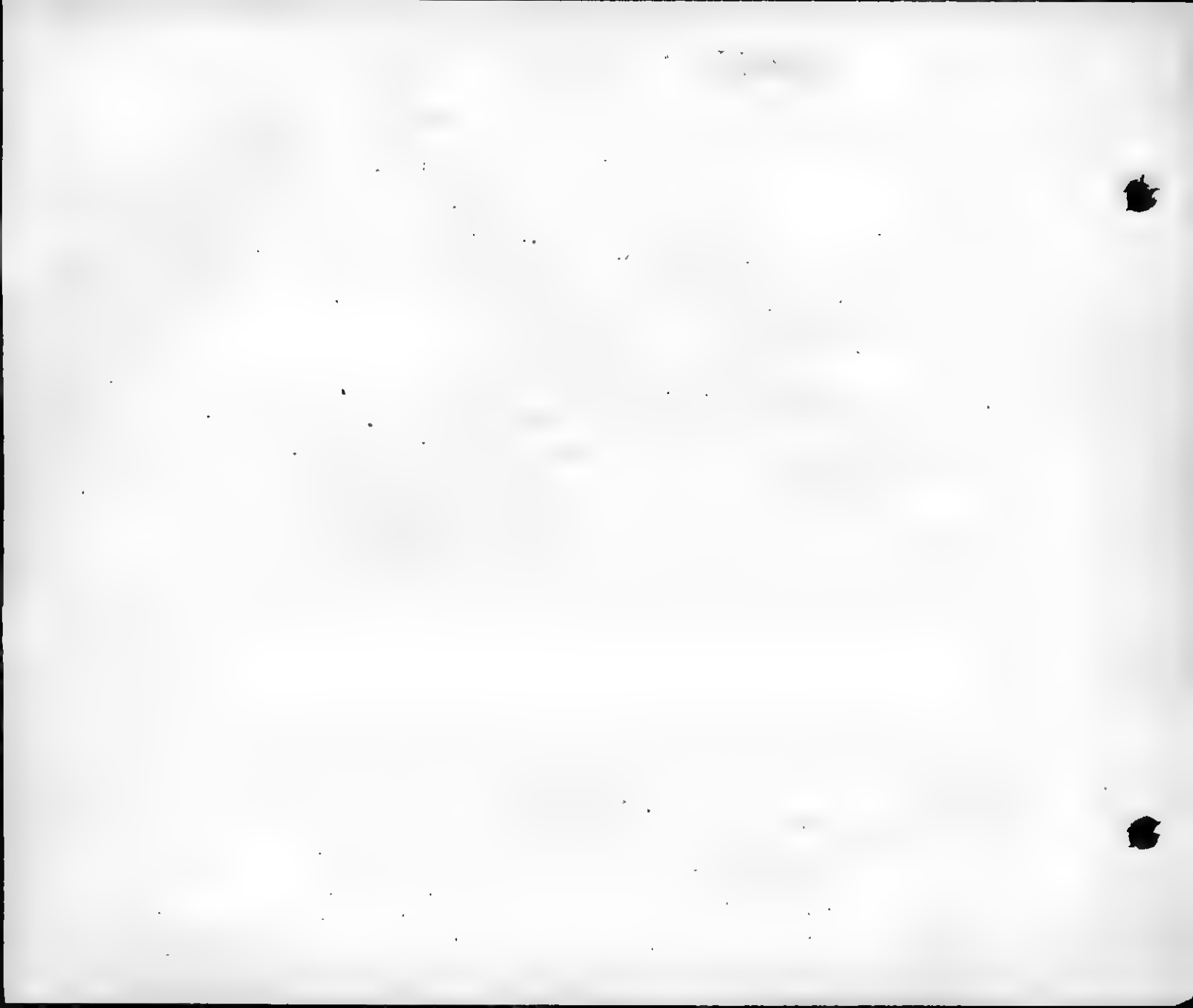


## CERTIFICATE OF DEATH

Reg. Dist. No.

13316

1. PLACE OF DEATH a. COUNTY <i>GA Co Md</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leve</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>GA Co</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leve</i> d. STREET ADDRESS <i>909 Lynwood Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <i>Daniel Blase Tasha</i>		4. DATE OF DEATH <i>Month Day Year</i> <i>Dec 3-59 19</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 12-1957</i>
9. AGE (In years last birthday) <i>2 yrs</i>		10. IF UNDER 1 YEAR <i>3</i> Months Days	11. IF UNDER 24 HRS <i>Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Melvin Blase Tasha</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Mary Gibbons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Daniel B Tasha</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medulla Oblongata</i> <i>173.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			INTERVAL BETWEEN ONSET AND DEATH <i>173.0</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Birth</i> , 19... to <i>12/3</i> , 19... that I last saw the deceased alive on <i>11/13</i> , 19... and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>204 Crain Hwy, SW.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Julius Loebl, M.D.</i>			
PHYSICIAN'S NAME (Type) <i>Julius Loebl, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec 5-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Calverton</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward G. T. mdc</i> ADDRESS <i>John Brown</i>		24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>



13317

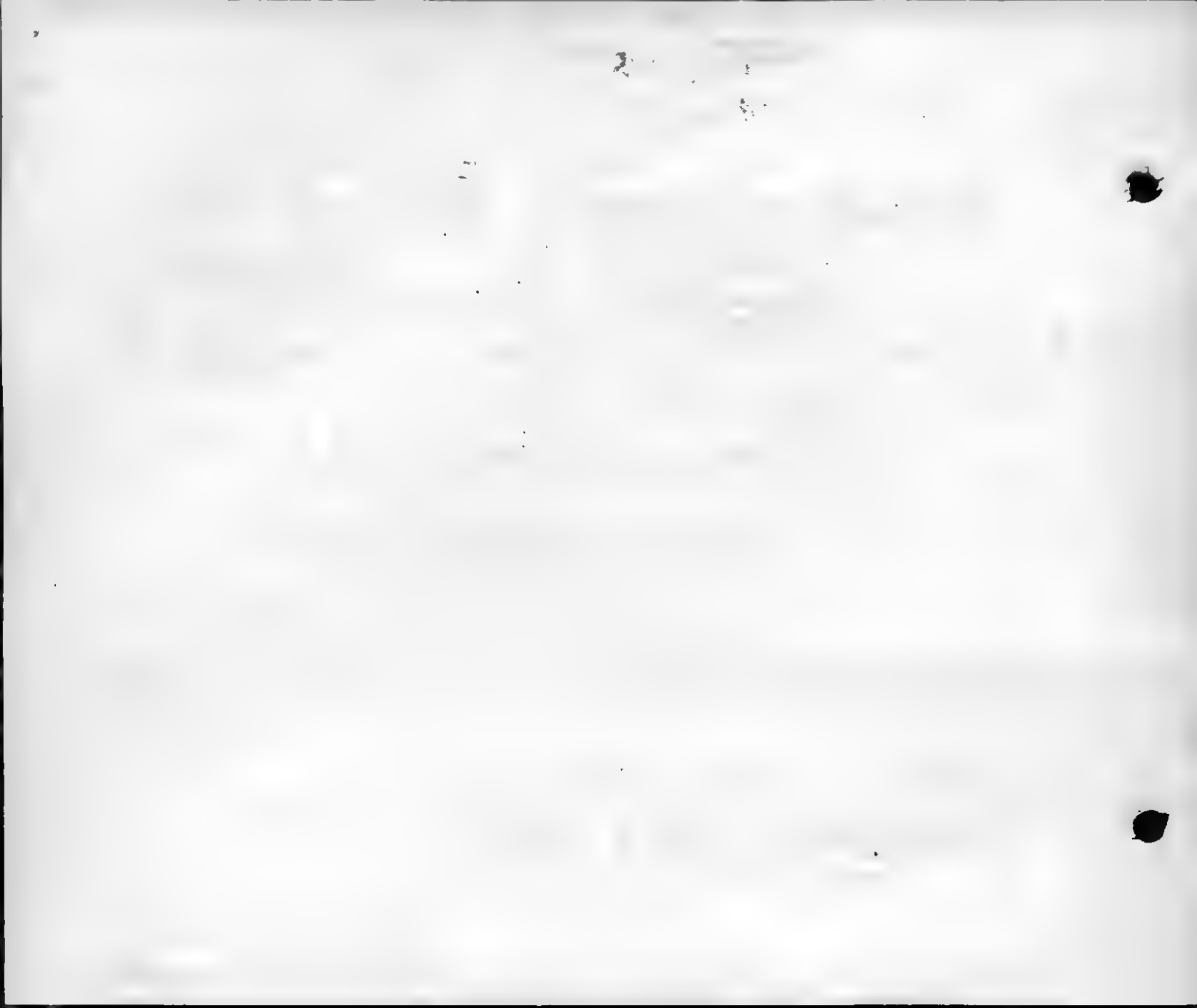
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wallerstille</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barn Nursing Home</u>		d. STREET ADDRESS <u>Wallerstille Md</u>	
3. NAME OF DECEASED (Type or print) <u>Clinton B Taylor</u>		4. DATE OF DEATH <u>Dec 23</u> 19 <u>59</u>	
5. SEX <u>M.</u>	6. COLOR OF HAIR <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 - 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Va</u>
13. FATHER'S NAME <u>American V. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Shirley C. Hardisty Edgewater Md</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Arteriosclerotic Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Amputation Left Leg</u> DUE TO (c) <u>Amputation Left Leg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 28 - 59</u> to <u>Dec 23 - 59</u> , that I last saw the deceased alive on <u>Dec 23 - 59</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above		DATE SIGNED <u>12/23/59</u>	
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKEY</u> M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Goodland Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Goodland Ci. Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rebecca Hardisty Edgewater Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Clara E. Hume</u>

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13263

## CERTIFICATE OF DEATH

Reg. Dist. No.

13298

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>Deale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Locust Drive, Porthaven</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>M</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>10-19-1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seaming Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Stafford Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>YES</u>	
17. INFORMANT <u>Paul A. Taylor</u>		Address <u>Deale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic ht. disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec. 23, 1959</u> to <u>Dec. 23, 1959</u> , that I last saw the deceased alive on <u>Dec. 23, 1959</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u>		DATE SIGNED <u>12/23/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Smiths Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>517-11<sup>th</sup> St SE</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



13318

## CERTIFICATE OF DEATH

13293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prin. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>THOMAS</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9-1873</u>		9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver - Baltimore Transit Co</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J Thomas</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-7803</u>		17. INFORMANT <u>Edna E. Thomas - Pasadena, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4/100</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Failure - Sclerotic Cardiovascular Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-21-1959</u> to <u>12-31-1959</u> , that I last saw the deceased alive on <u>12-21-1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Febus Groube</u> M.D. <u>P.O. Box 37</u>				DATE SIGNED <u>1-1-60</u>			
PHYSICIAN'S NAME (Type) <u>Febus Groube</u>				ADDRESS (Street, city or town, state) <u>Odenton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 4-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore - Westbury</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore - Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos J. Brown</u> ADDRESS <u>1300 Eastland Pl</u>				24a. REC'D BY REGISTRAR <u>DAEN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13300

13264

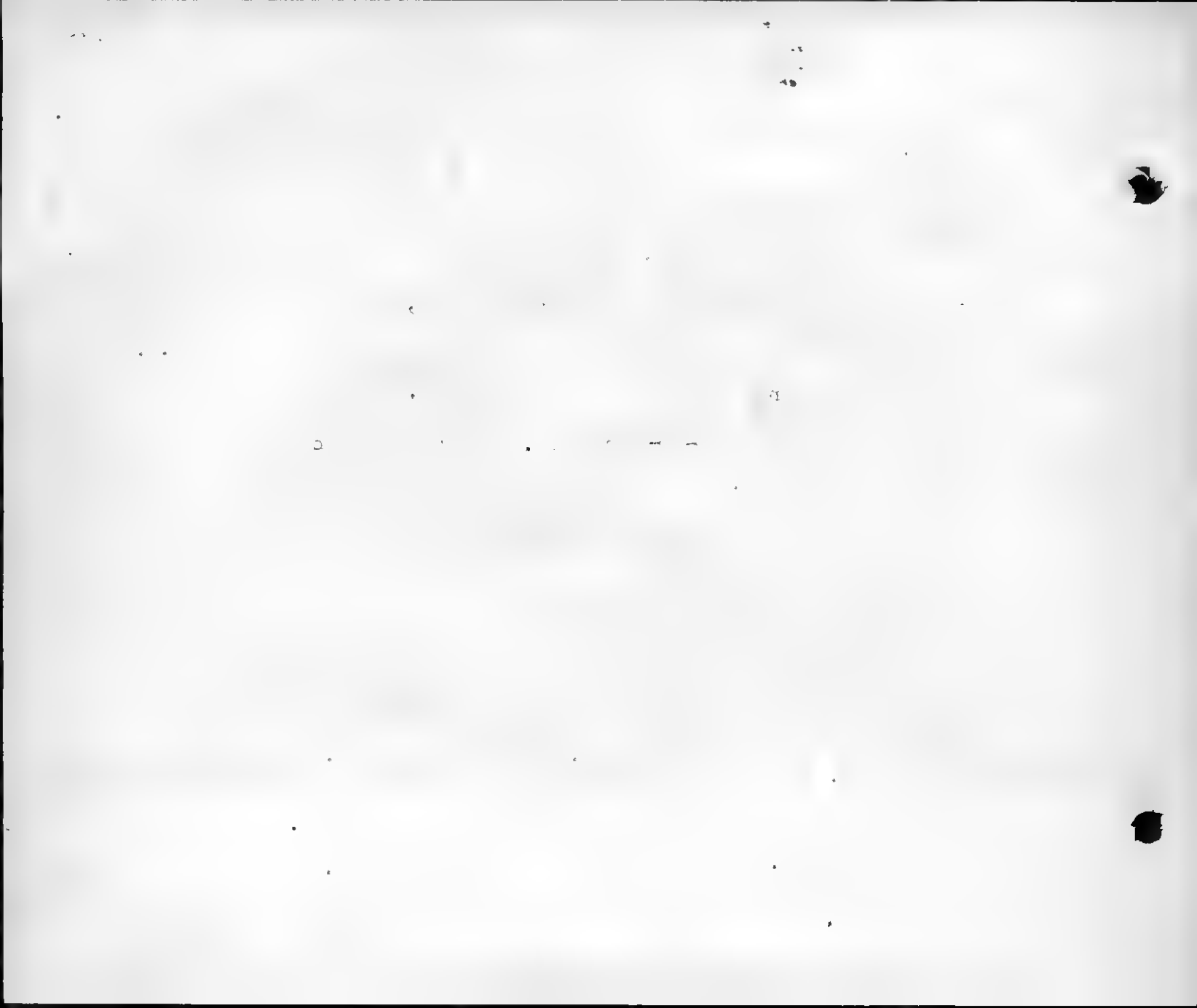
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11</b>	
f. STREET ADDRESS <b>4021 Falls Road,</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H.</b> Last <b>THORNEY, Jr</b>		4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 28, 1900</b>
9. AGE (In years lost birthday) <b>59</b> yrs		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pullman conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Henry Thorney</b>		14. MOTHER'S MAIDEN NAME <b>Edith V. Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>709-09-0913</b>	
17. INFORMANT <b>Mrs. Margaret Ruth Thorney</b>		Address <b>4021 Falls Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>DISSECTING ANEURYSM OF AORTA</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 27, 1959</b> to <b>Dec. 28, 1959</b> that I last saw the deceased alive on <b>Dec. 28, 1959</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>41 Southgate Ave.,</b> DATE SIGNED <b>Edward S. Beck</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b> <b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 31, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		ADDRESS <b>3631 Falls Road</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13319

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>ANNE ARUNDEL Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA B A C</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA - R A C</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 277 - Poplar Ridge Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>AGNES</i> First <i>IDA</i> Middle <i>TIERNAN</i> Last				4. DATE OF DEATH <i>Dec 21</i> Month <i>Dec</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>Fem</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 4 - 1888</i>		9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>AT MARYS Co - Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>MATTINGLY</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>215-14-6705</i>		INFORMANT <i>MRS MARGARET ROBINSON Pasadena, Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> (c) <i>Generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i> <i>5 years</i> <i>5 years</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hypertrophic osteoarthritis</i> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 19, 1958</i> to <i>December 21, 1959</i> , that I last saw the deceased alive on <i>Dec. 21, 1959</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>				ADDRESS (Street, city or town, state) <i>Box 442 Pasadena, Md.</i> DATE SIGNED <i>Dec. 21, 1959</i>			
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-24-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>		22d. LOCATION (City, town, or county) (State) <i>4300 Oak Avenue Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>THOMAS J KENNY</i>				ADDRESS <i>1600 Hollins St Baltimore Md</i>		24a. REC'D BY REGISTRAR <i>DEC 22 1959</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

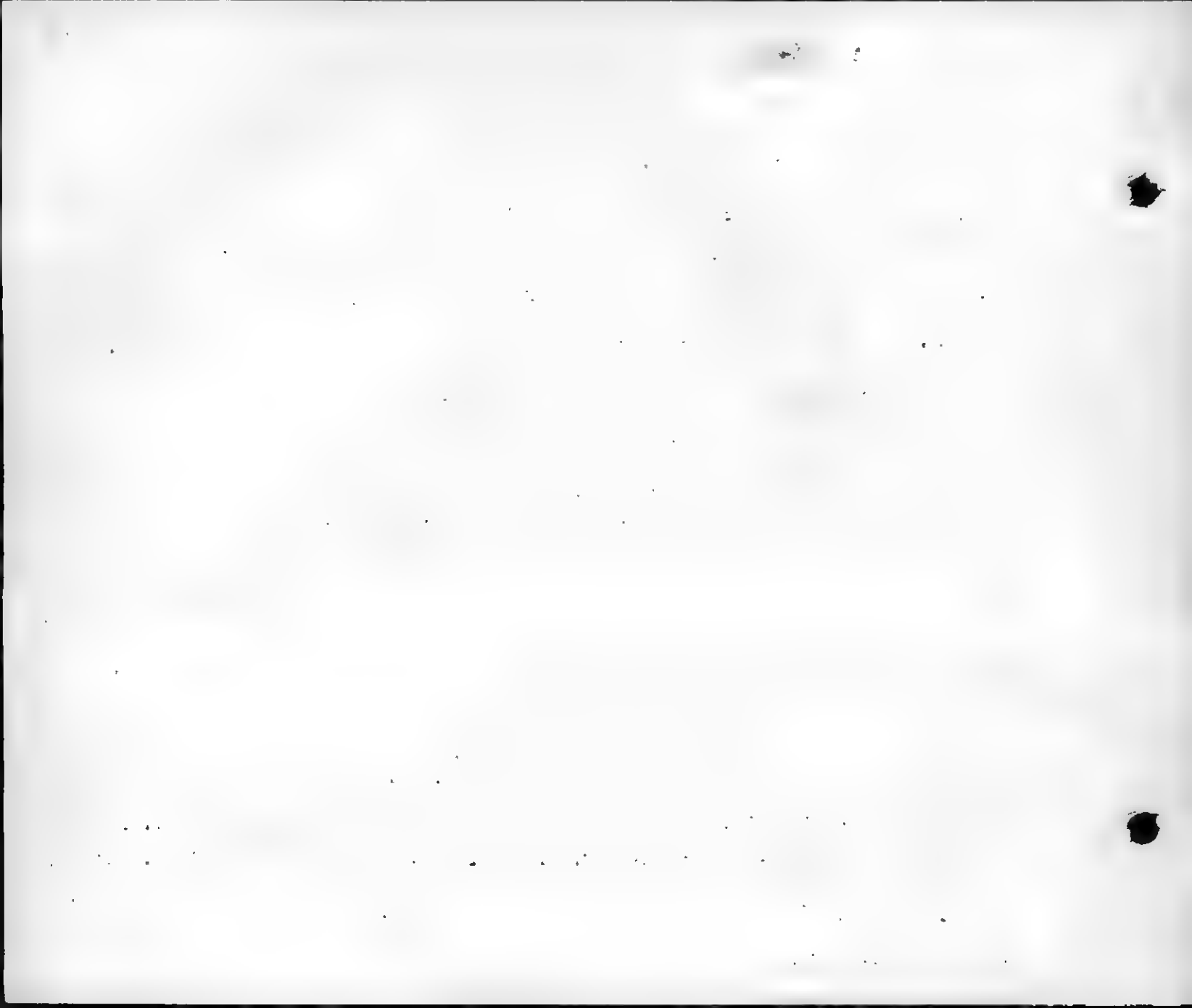
13320

CERTIFICATE OF DEATH

Reg. Dist. No.

13303

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN IL <b>6 years</b> <b>8 mo. 2 days</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>			
2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Prince George's</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntsville</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b>				Middle <b>Washington</b>				Last <b>Washington</b>				4. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>November 25, 1885</b>		9. AGE (In years last birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>17</b>		11. IF UNDER 24 HRS Hours <b>17</b> Min. <b>1959</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Washington</b>								14. MOTHER'S MAIDEN NAME <b>Catherine</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> <b>420.1</b> DUE TO <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disease</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Since Admission</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>-----</b> p. m. <b>-----</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) <b>-----</b>				20f. (City or town) (County) (State) <b>-----</b>			
21. I certify that I attended the deceased from <b>4/15</b> , 19 <b>53</b> , to <b>12/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/17</b> , 19 <b>59</b> , and that death occurred at <b>2:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>12/17/59</b>															
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b> M.D. <b>Crownsville State Hospital, Md. 12/17/59</b>															
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b> <b>Crownsville State Hospital, Md. 12/17/59</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-23-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery 4611 Benning Rd. S.E. Wash</b>				22d. LOCATION (City, town, or county) (State) <b>-----</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>45 W Washington Ave 4935 Danabul</b>				ADDRESS <b>W.D.C.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 24 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

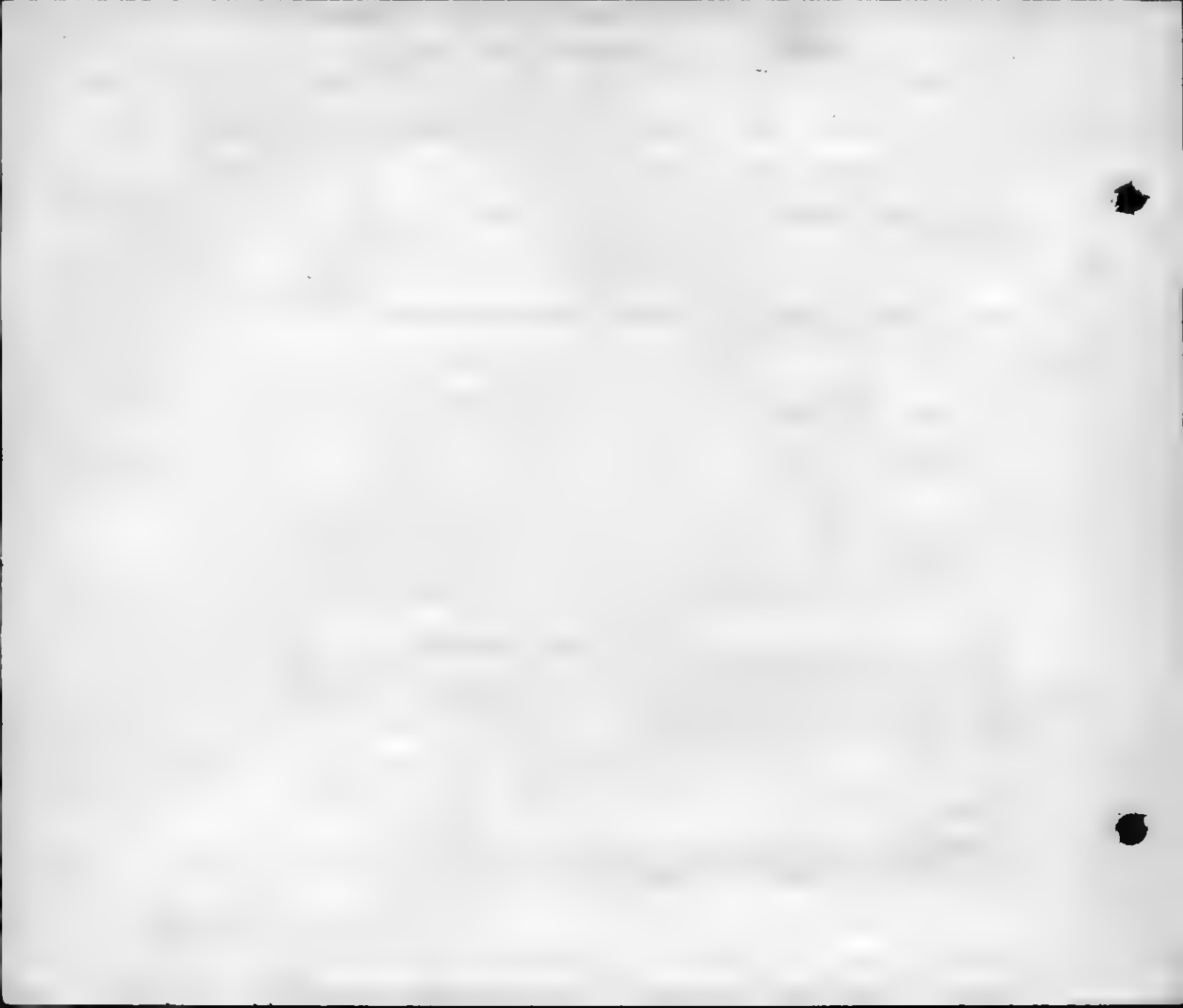
13321

## CERTIFICATE OF DEATH

Reg. Dist. No. 13304

1. PLACE OF DEATH o COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk River</u> <u>Idaho</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Minor Wesleyan</u>		d. STREET ADDRESS <u>2007 Elsworth Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Washington</u> First Middle Last		4. DATE OF DEATH <u>Dec.</u> <u>8</u> <u>1959</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Unknown</u>		<u>Unknown</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>ms. Thalia Julia</u> Address <u>2007 Elsworth</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>44XX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Systemic Arterial Hypertension</u> DUE TO (c) <u>Dissecting Aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/1</u> 19 <u>59</u> to <u>12/8</u> 19 <u>59</u> that I last saw the deceased alive on <u>12/1</u> 19 <u>59</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Felix Grunberg</u> M.D.		ADDRESS (Street, city or town, State) <u>P.O. Box 91</u> DATE SIGNED <u>12/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Felix Grunberg</u>		<u>Odenton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt. Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>Balt.</u> <u>md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Jordan</u> ADDRESS <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 59</u>	24b. REGISTRAR'S SIGNATURE

916 Penna. Ave. H. 1

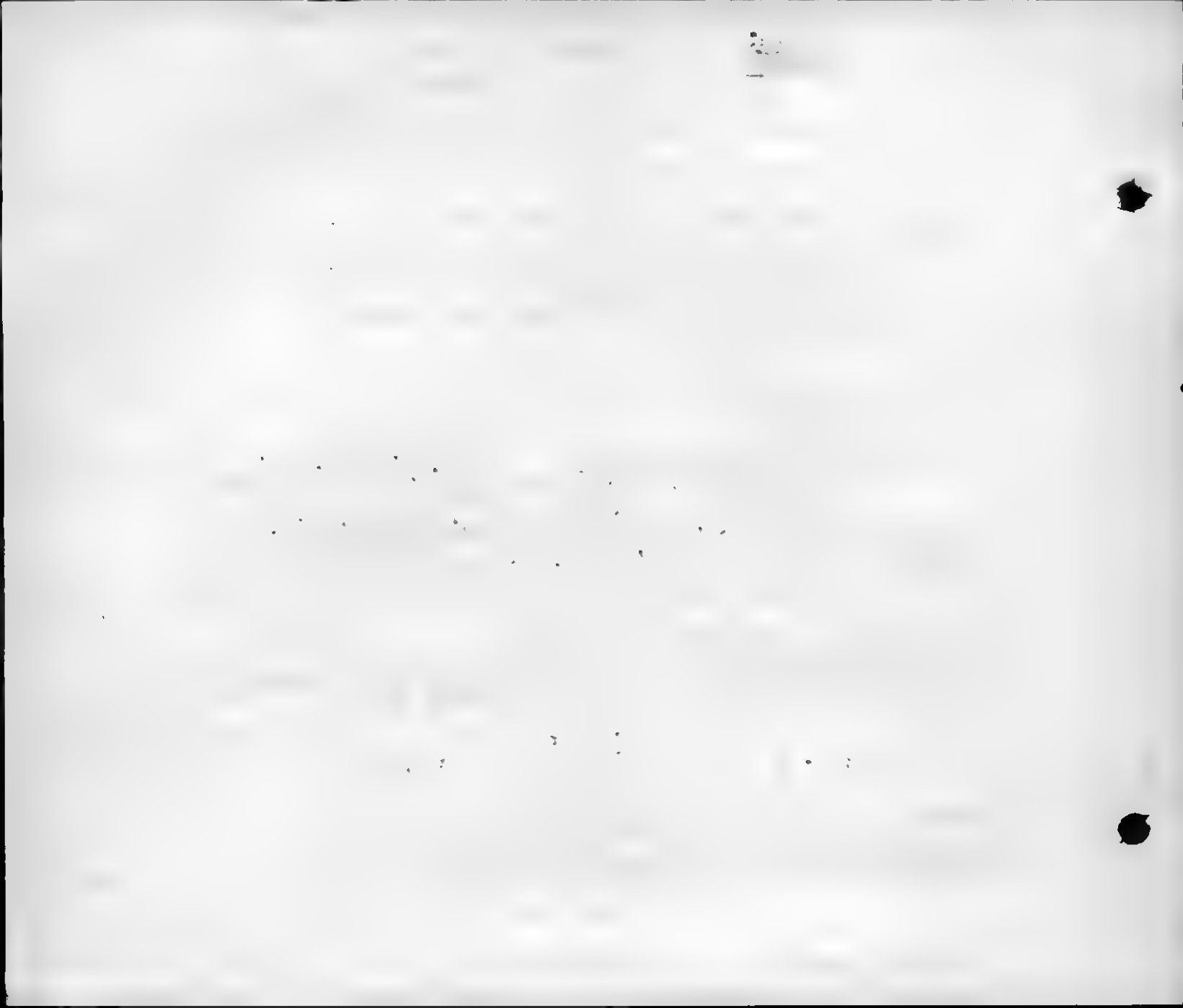


may be relied upon by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>11 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore city</u>			
f. STREET ADDRESS <u>2650 Harlem Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eivarge</u> Middle <u>Whipple</u> Last <u>Whipple</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>?</u> Days <u>?</u> Hours <u>?</u> Min <u>?</u>		IF UNDER 24 HRS: Hours <u>?</u> Min <u>?</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Robert Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Ruth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Medical Record</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, terminal</u>							
DUE TO <u>Inanition and dehydration</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alzheimer's disease</u>							
DUE TO <u></u>							
DUE TO <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> a. m. <u>?</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/1/57</u> 19 <u>57</u> to <u>12/19</u> 19 <u>59</u> , that I last saw the deceased alive on <u>12/19/59</u> , 19 <u>59</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>CROWNSSVILLE STATE HOSPITAL</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>L. BENEDETTO</u> M.D. <u>CROWNSSVILLE, MD</u>							
PHYSICIAN'S NAME (Type) <u>L. BENEDETTO MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mount Airy (Baltimore) Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u> ADDRESS <u>22224 North St</u>				24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u></u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13306

13323

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Quoted)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 Gloucester Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 July 1885</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Nickels</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Usinger Dam. A. Fil.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1955</u> to <u>December 3, 1959</u> , that I last saw the deceased alive on <u>December 3, 1959</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>RE-08 Box 442 Pasadena, Md</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				DATE SIGNED <u>Dec 3, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 1959</u>		<u>Mount St. Mary's</u>		<u>A. A. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Sargent</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13266

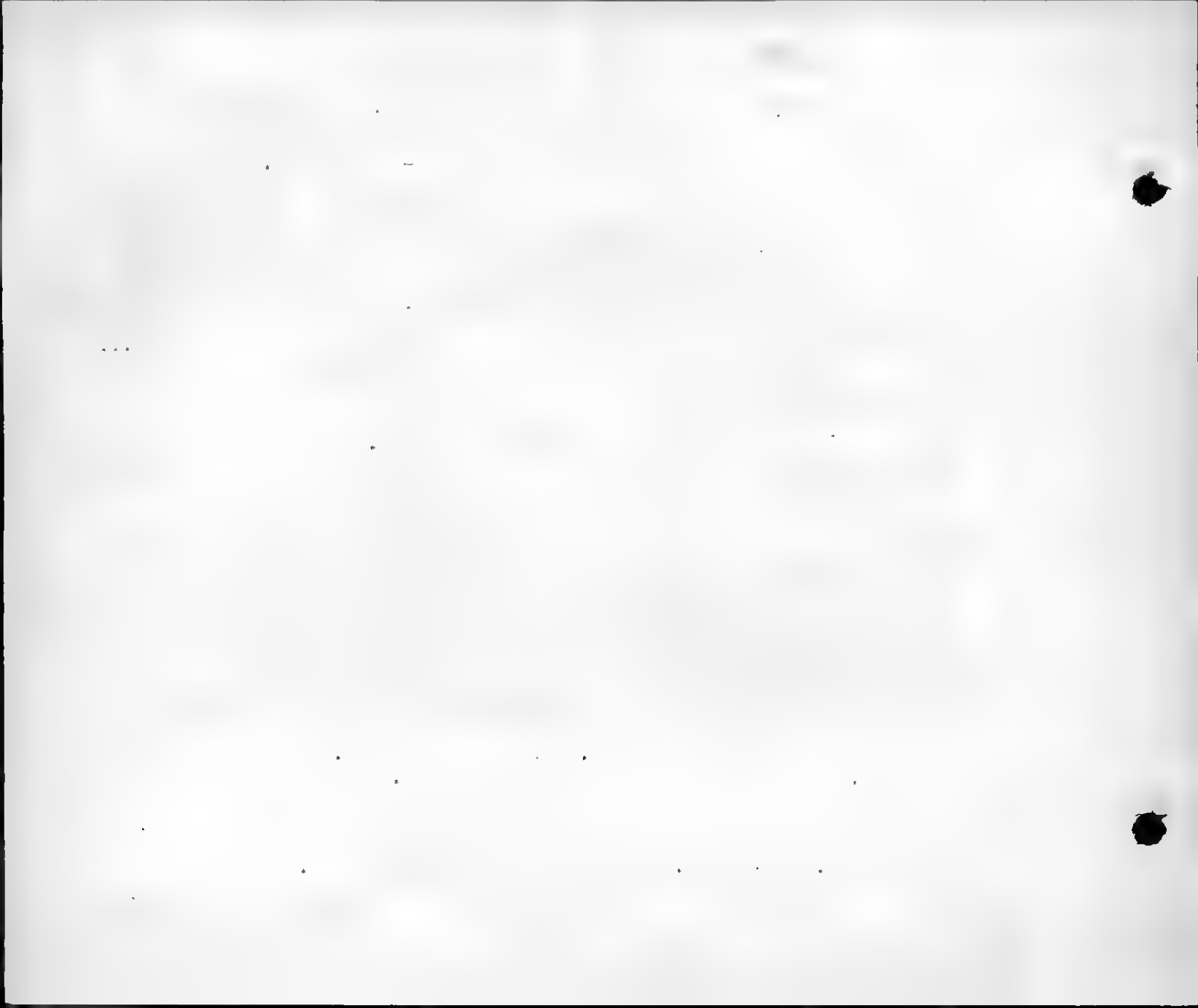
CERTIFICATE OF DEATH

13307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Arnold, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-1, Box-12A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lorie</b> Middle <b>Michele</b> Last <b>WILLIAMSON</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 13, 1959</b>	
9. AGE (In years lost birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>55</b>		IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>55</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Donald Clift WILLIAMSON</b>				14. MOTHER'S MAIDEN NAME <b>Ruth MASTEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>Hospital records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>25 hr.</b> <b>25 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec. 13, 1959</b> to <b>Dec. 14, 1959</b> , that I last saw the deceased alive on <b>Dec. 14, 1959</b> at <b>1:00 P.M.</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James I. Hudson, Jr.</b>				ADDRESS (Street, city or town, state) <b>River Club Estates</b> DATE SIGNED <b>12/15/59</b>			
PHYSICIAN'S NAME (Type) <b>James I. Hudson, Jr.</b>				Edgewater, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>12-15-59</b>		<b>HILLCREST</b>		<b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam M. [Signature]</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13324

## CERTIFICATE OF DEATH

Reg. Dist. No.

13308-

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Kimberly Ct</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park</u>		e. STREET ADDRESS <u>17 Kimberly Ct</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Beatrice Woodruff</u>		4. DATE OF DEATH <u>Dec 30 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Howard Forest</u>		14. MOTHER'S MAIDEN NAME <u>Jane A. Wadsworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-111111</u>	
17. INFORMANT <u>Dr. J. H. H. H.</u>		Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Atherosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>1957</u> 19 <u>57</u> to <u>1959</u> 19 <u>59</u> that I last saw the deceased alive on <u>12-29-59</u> 19 <u>59</u> and that death occurred at <u>11 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Halpin</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Halpin</u>		DATE SIGNED <u>12-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2 Jan '60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knease</u>	

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from 1957 1957 to 1959 1959 that I last saw the deceased alive on 12-29-59 1959 and that death occurred at 11 A M. from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R. Halpin M.D. ADDRESS (Street, city or town, state) Severna Park, Md. DATE SIGNED 12-30-59

PHYSICIAN'S NAME (Type) Robert R. Halpin

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2 Jan '60 22c. NAME OF CEMETERY OR CREMATORY Landon Park 22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE R. J. Singleton ADDRESS Glen Burnie, Md. 24a. REC'D BY REGISTRAR JAN 4 '60 24b. REGISTRAR'S SIGNATURE William S. Knease

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6254 12-30-59 ea.

## CERTIFICATE OF DEATH

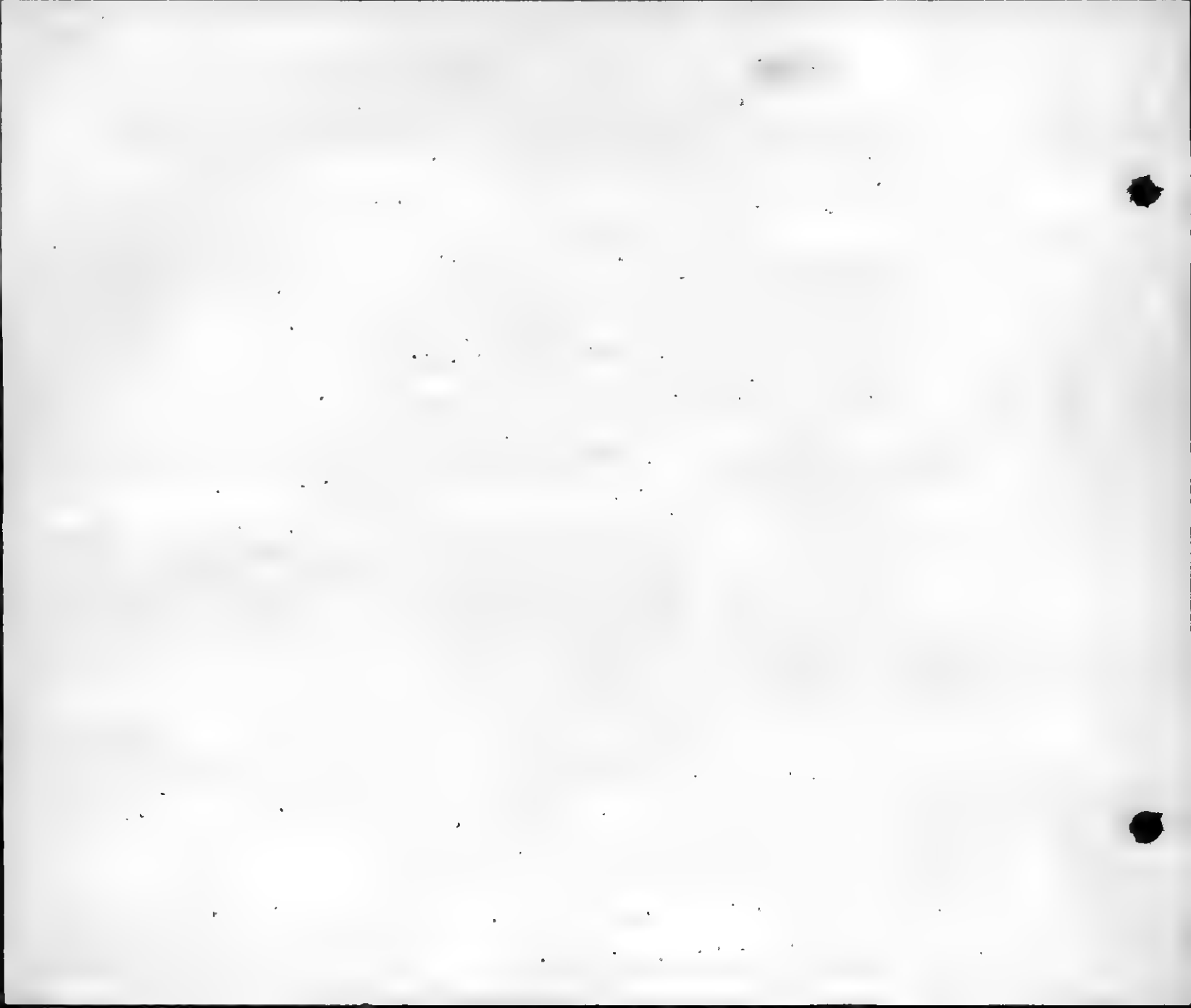
13309

Reg. Dist. No.

13325

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">AA</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <span style="font-size: 1.2em;">Glen Burnie PO</span> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">327 Cherry Lane</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Glen Burnie</span> d. STREET ADDRESS <span style="font-size: 1.2em;">327 Cherry Lane</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <span style="font-size: 1.2em;">Rose</span></span> <span>Middle <span style="font-size: 1.2em;">L.</span></span> <span>Last <span style="font-size: 1.2em;">Woodward</span></span> </div>			<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <span style="font-size: 1.2em;">12</span></span> <span>Day <span style="font-size: 1.2em;">19</span></span> <span>Year <span style="font-size: 1.2em;">1959</span></span> </div>				
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11-30-68</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">91</span> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">house wife</span>		<b>11. BIRTH PLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles Lawery</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">unknown</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">- - - - -</span>		<b>INFORMANT</b> <span style="font-size: 1.2em;">Family</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <span style="font-size: 1.2em;">422.1</span> DUE TO <span style="font-size: 1.2em;">acute Coronary Failure</span>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>  <span style="font-size: 1.2em;">Intermittent Cardiac Arrhythmia</span> </div> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  					<b>INTERVAL BETWEEN ONSET AND DEATH</b>  		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month. Day. Year Hour a. m. p. m. <span style="font-size: 1.2em;">19</span>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>  (County) (State)		
<b>21. I certify that I attended the deceased from</b> <span style="font-size: 1.2em;">Jan 1, 1959</span> <b>to</b> <span style="font-size: 1.2em;">Dec 20, 1959</span> <b>that I last saw the deceased alive on</b> <span style="font-size: 1.2em;">Jan 20, 1959</span> <b>and that death occurred at</b> <span style="font-size: 1.2em;">74 M.</span> <b>from the causes and on the date stated above.</b> <div style="display: flex; justify-content: space-between;"> <div> <b>ACTUAL SIGNATURE</b>  <span style="font-size: 1.2em;">Louis J. Galt</span> </div> <div> <b>ADDRESS</b> (Street, city or town, state)  <span style="font-size: 1.2em;">320 Patapsco Rd, Baltimore, Md</span> </div> <div> <b>DATE SIGNED</b>  <span style="font-size: 1.2em;">Dec 21, 1959</span> </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <b>PHYSICIAN'S NAME (Type)</b>  <span style="font-size: 1.2em;">Louis J. Galt</span> </div> <div> <b>ADDRESS</b>  <span style="font-size: 1.2em;">320 Patapsco Rd, Baltimore, Md</span> </div> </div>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">12/22/59</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Cedar Hill Cem.</span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">McCully Funeral Homes 130 E. Fort Ave.</span>				<b>24a. REC'D BY REGISTRAR</b> DATE <span style="font-size: 1.2em;">DEC 24 '59</span>			
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Knecht</span>				<b>24c. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Knecht</span>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13326

CERTIFICATE OF DEATH

Reg. Dist. No.

13310

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>8 months 6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1723 Madison Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>Hall</u> Middle <u>Wright</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27/911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic (housework)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Henry Wright</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Elizabeth Pitt</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT Address <u>Crownsville State Hosp. Medical Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 300.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration and Inanition</u> DUE TO (c) <u>Schizophrenic Reaction Paranoid Type</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction Paranoid Type</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>April 4th</u> 19 <u>59</u> to <u>December 26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>December 26</u> 19 <u>59</u> , and that death occurred at <u>2<sup>00</sup></u> P.M., from the causes and on the date stated above.			
21. I certify that I attended the deceased from <u>April 4th</u> 19 <u>59</u> to <u>December 26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>December 26</u> 19 <u>59</u> , and that death occurred at <u>2<sup>00</sup></u> P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>Dec 27/1959</u>			
ACTUAL SIGNATURE <u>Enrique J. del Campo</u>				PHYSICIAN'S NAME (Type) <u>Enrique Julio del Campo</u> <u>Crownsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-23-59</u>		<u>MT. CALVARY</u>		<u>BALTIMORE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. BROOKS RINGOLD</u> ADDRESS <u>1463 N. CAREY</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 28 59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1888

1888

Blank lines for recording death information.

13327

## CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G Meade</b>				c. LENGTH OF STAY IN TB <b>2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U. S. Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>L</b> Last <b>ZYLINSKI</b>				4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Feb 1896</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Zylinski</b> <b>Daughter-in-law</b>		Address <b>Dorsey, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>21 December 1959</b> , to <b>23 December 1959</b> , that I last saw the deceased alive on <b>23 December 1959</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>M. J. MYERS, M.D.</b> M.D. <b>USA Hospital Ft. Geo G Meade, Md</b> <b>23 Dec 59</b> PHYSICIAN'S NAME (Type) <b>M. J. MYERS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12'26'59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**Dr. Lynda M. Davis**